Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registra MEND#23 openMD, 9-23-09, BMW, MoCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 9:00 am Lydia F. Levinson September 20, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery 6607 Old Stage Road Rockville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Months Hours 1 M 2 K F Yrs. 91 275-03-0070 Director September 6,1918 Ohio Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6607 Old Stage Road 20852 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify þ Specify: 3 ₩idowed 4 Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Education Secretary .. Pages 1 and 2 should be filed w tment of Health and Mental Hygie tant: If item 27 Is marked other ti jury or other traumatic event, th other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Gruber Lillian Bonowitz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31 Hollyberry Court, Rockville, Maryland 20852 Sandra L. Brecher - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ■ Burial 2 □ Cremation 3 ■ Removal from State permit. Page Department o Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) Rose Hill Cemetery 09/24/2009 Akron, Ohio 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** pheuminia /Medical Examiner A12 heimer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Physician: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of): physician for use as the IF FEMALE: . If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) the detached 9□Unknown 9 ☐ Unknown þ signed k d be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by me 11. tus 1 Tes 2 No 3 Probably 4 Unknown 2 should has been Fibrillation 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was ... autopsy performed? Ves 2 No page certificate 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Tesidence 6 Other (Specify) To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: or Attending 1 Natural 5 Pending Injury death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital 1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29c. License number 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) De D12523

State Registrar

DHMH 17 Rev 1/2001

Maryland 21215-0036

Baltimore,

Division or Vital Records, P.O. Box 68760,

Bockledge

Drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6430

22. Registrar's Signature

3

31. Date filed (Month, Day, Year)

· Wilks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 8:45 pM September 20, 2009 Lea Leibovici 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Montgomery Kensington Kensington Nursing & Rehabilitation Center Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Hours Months Davs 1 □ M 2 🗷 F Romania December 6, 1920 None 88 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 1 ☐ Yes 2 🛣 No Silver Spring Montgomery Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Israel 20902 1305 Arbor View Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🔼 No Specify Specify. White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Miriam Rothman Leopold David 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1305 Arbor View Road, Silver Spring, Maryland 20902 Vera Briel - Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Adelphi, Maryland 09/22/2009 Mt. Lebanon Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Colehrovascular Immediate Cause (Final Accident

D0064624 September 22, 2009

Walk Dr., Geitherburg, MD 20878

**Physician** /Medical Examiner

certificate be executed

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Examiner

10a. State

Director

Funeral

2

Completed

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**Funeral** 

Director

ed other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than

permit. Pages 1 Department of I Important: If ite any Injury or ol

Examiner attending physician and for use as the burial-transit Physician/Medical Hospital or Attending Physiclan: The law requires that the death of hours after death.
Funeral Director: After this certificate has been signed by the atten signed by the a d be detached for 2 Be Completed Certification: To filled in by the

disease or condition			
resulting in death)	Due to (or as a consequence of):		79
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b		-
that initiated events resulting in death) Last	c Due to (or as a consequence of): d		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregnancy  1  Live birth 2  Fetal death 3  Ectopic pregnancy  4  Pregnant at time of death 9 Unknown	23d	Date of delivery Month Day Year
Part II. Other significant conditions	ontributing to death but not resulting in the underlying cause given in Part I.		contribute to the cause of death?
		24a. Was an autopsy performed? 1 □ Yes 2 □ No	4b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No
25. Was case referred to medical	26. Place of Deat	th (Check only one)	
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Ho	ome 5 Residence 6	Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury Injury  28c. Injury at Work?  1 □ Yes 2 □ No	28d. Describe how injury of	ccurred
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and N City or Town, State)	lumber or Rural Route Number,
29a, Certifier 1 Certifying Pl	nysician: To the best of my knowledge, death occurred at the time, date and place	, and due to the cause(s) ar	nd manner as stated.
200. Contino	The second secon	a sat the state and all	and due to the equec(e)

State Registrar

Medical

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

(Check only

SANDEEP

743 Summer

MD

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

SHARMA

23

DHMH 17 Rev 1/2001

24 hours a

To the within 2

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2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Leonce Arnold Lajaunie, Jr. September 18, 2009 9:30 pM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Renaissance Gardens at Riderwood Village Silver Spring Prince Georges If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth
Manths Days Hours Min. (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 6. Sex **Funeral** 12 M 2 . F Days 94 Yrs. 433-58-0129 Sept. 21, Director 1914 Panama Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Madical Examinar must be notified at Director 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3118 Gracefield Road, CC520 20904 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1933–63 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examinations. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Captain United States Navy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leonce Aurelie Lajaunie Marie Champagne ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean H. La jaunie/Wife 3118 Gracefield Road, CC520, Silver Spring, MD 20904 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Sept. 2009 28, U.S. Naval Academy Annapolis, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the visease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hilure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Interstitial Lung Disease disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Clusease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Box 68760. Be Completed by Physician/Medical the IF FEMALE 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery Live birth 2 Fetal death 3 - Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part !. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. Alzheimer's Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Anursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident the 1 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature apd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D36716 September 21, 2009 0+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Andrew Kundrat, MD 3110 Gracefield Road, Silver Spring, MD 20904 31. Date filed (Month, Day, Year) State 32. Registrar's Signature

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Registrar

23

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Month **Physician** 4NIEL 2120 M 0 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mandrin Chesapeake Hospice House Anne Arundel Harwood 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Min. Director 123-28-1753 72 Aug. 16,1937 New York Usual Residence of Decedent 10a. State show 10b. Count 10c. City. Town or Location 10d. Inside City Limits MD Anne Arundel Severna Park 7 is marked other than "natural", or items 23a or 28a-f st traumatic event, the My dical Examine rule by motified Director 1 ☐ Yes 2 📉 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 76 Saint Andrews Road 21146 USA Funeral death 1 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itel 1 ☐ Never Married 2 🔀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 2 Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Department of Defense Federal Employee 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry F. Lewis Gertrude S. Schwartz ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any Injury or other traun once. Rosalie A. Lewis / Wife 76 Saint Andrews Road Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place)
Atlantic Crematory, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Sept. 18 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 2009 IIC21. Signature of Funeral Service License. Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Exami burial-tran and Due to (or as a consequence of): P.O. Box 68760. ettending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) MANDRIN Other: 4 \sum Nursing Home Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 Residence 6 Other (Specify) MCE 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 40435 Division 5 Pending investigation Injury 1 ☐Yes 2 ☐No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

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State

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32. Registrar's Signature

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# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		_	For State Registrar		TIC OI WIG		•	tificate of		,	Reg	. No. 2	000	52005
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	Medic camin		4a. Facility Name (If not institut	ion, give street	,			4b. City, Town, or		eath	91,	4c. Coun	ity of Death	
	neral		FININ 346 G S  5. Social Security Number	6. Sex	M/0	ICAL e (In vrs. la	CANTU st birthday)	If Under 1 Year	54/1564 If Under 24 H		e of Birth		9. Birthr	lace (State or Foreign
	ector		143-26-8811	1 □ M 2		76	Yrs.	Months Days		8/4	of Birth nth, Day, Y	ear)	Cour	NJ
/land	Ħ		Usual Residence of Decedent  10a. State 10b. Cour	ty		10c. City,	Town or Loc	ation					1	0d. Inside City Limits
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death	Chius	Funeral	40 Liberty S	12. W	as Decedent med Forces?	Ever in U.S	. 13. V	21811 Vas Decedent of H Yes, specify Cuba	lispanic Origin?	(Specify Yes	s or No-	14. R	ace - Americ	
G Z IZ I 3-UU35 filed within 72 hours after death with the Maryland Hygiene. ther than "natural"; or items 23a or 28a-f show	the Medical Exercitor is ust be notified at	by Fu	1 ☑ Never Married 2 ☐ M 3 ☐ Widowed 4 ☐ Divorc	arried 1 [	□Yes 2[X]I res, Give	No		☐Yes 2X No	Specify:	ierto i noan, c	,,,,,	Spec	lack, White, o	ite
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and 2 streath and m 27 is n	r traun		19a. Informant's Name/Relation Coralie Miller					g Address <i>(Street</i> Magnolia				-		
0	or other traun		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematio			20b. Pla		sition (Name of latory or other place		Date			n - City or To	
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ath certific		/Me	IF FEMALE: 23b. Was decedent pregnant		yes, outcome							23d [	Date of delive	erv
death be afte	ed for	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 [	☐ Live birth ☐ Pregnant a ☐ Unknown			Ectopic pregnance Other (specify)	у				Month	Day Year
that the	detach		9 ☐ Unknown / Part II. Other significant cond			ut not resul	ting in the un	derlying cause give	en in Part I.	236	e. Did toba	cco use co	ontribute to the	ne cause of death?
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nysicia nysicia is cert	directo	To Be	25. Was case referred to medic examiner?  1 ☐ Yes 2 No	Hospita	tl: 1 npatie	ent 2 🗆 E	R/Outpatien	3 DOA Oth	26. Place of Der: 4 ☐ Nursing	Death <i>(Check</i> g Home 5 [		ce 6 □ C	ther (Specif	·v)
Ilng Phy After this	funeral	ion	27. Manner of Death 1. ■Natural 5 □ Pend	ling	a. Date of Inju (Month, Da	ry y, Year)	28b. Time of Injury	28c. Injur Work	</td <td>28d. De</td> <td>scribe how</td> <td>injury occ</td> <td>urred</td> <td></td>	28d. De	scribe how	injury occ	urred	
Attending r death.	by the	Certification:	3 ☐ Suicide 6 ☐ Coul	d not be	e. Place of Inju	ury - At họn	ne, farm, stre	M 1 □ et, factory, office	Yes 2 □ No	28f. Loc	ation_(Stree	et and Nur	mber or Rura	il Route Number,
ltal or irs afte	lled In		4   Hornicide								or Town, S	,		
To the Hospital or Attending Physician: The law requires that the death ce within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the aftendir	letely fi	Medical	29a. Certifier 1 Certific (Check only one) 2 Medic	ring Physician al Examiner: C ar	: To the best on the basis of t	of my know f examinati ated.	ledge, death on and/or inv	occurred at the tirestigation, in my o	me, date and pla ppinion, death o	ace, and due ccurred at th	to the cau e time, date	ise(s) and and place	manner as s e, and due to	stated. the cause(s)
To the To the	comp	Me	29b. Signature and title of certif	ier				29c. Licens	e number		29d	l. Date sign	ned (Month,	Day, Year)
			NYO					100	06698	36	(	09/11	109	
6A20			30. Name and address of person	in who complete	ed cause of d	eath (Item :	23a) (Type, F 24111	11 St.	SAlish	URU	ma	21	801	
	Stat		31. Date filed (Month, Day, Yea	F 0000	32. Registra	ar's Signatu	ire	29c. Licens 29c. Licens 29c. Licens 29c. Licens	2,,,,,,,,	1	, , , , , ,	(	, - 1	
Re	gistra	1	SEP I	5 2009	Denn	m ,	B. A.	we						

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of M	-	ertificate of l		-	Reg. No.	9 32005
	Physicia Medic		1. Decedent's Name (First, Midd Beverly	ile, Last) Kay Murphy	Y			2. Date of Dea	nber 19 2	3. Time of Death 4
	Examin		4a. Facility Name (if not institution Washington		pital	4b. City, Town, o	r Location of Deatl		4c. County of Washir	
I	Funeral Director		5. Social Security Number 234234498		e (In yrs. last birthda) 3 5 Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt 8 / 2 1 /	th 9	9. Birthplace (State or Foreign Country Irginia
	Maryland 28a-f show otified at	Director	Usual Residence of Decedent  10a. State 10b. Count  MD Was	hington	10c. City, Town or Hagers					10d. Inside City Limits  XX□ Yes 2 □ No
	with the s 23a or 3 ust be no	Funeral Di	10e. Street and Number 144 N. Poto	mac Street		10f. Zip Code 2174	0		10g. Citizen of What	at Country?
9800	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "hatural", or items 23a or 28a-f show my hiury or other traumatic event, the Medical Examiner must be notified at 2009.	ted by Fur	11. Marital Status  **Married 2  Married 2  Married 3  Midowed 4  Divorce	If Van Ohio	Ever in U.S. 13	3. Was Decedent of Hif Yes, specify Cuba		pecify Yes or No- o Rican, etc.)		American Indian, White, etc. white
21215-0036	led within 72 ho Hygiene. other than "natent, the Medica	Completed by		lent's Education hest grade completed)  College (1-4 or 5	(Giv	cedent's Usual Occup ve kind of work done DO NOT use retired) omemaker	during most of wor	rking	16b. Kind of Busin	ness Industry
Maryland 2	i be filed w fental Hygi rked othe tic event,	To Be	17. Father's Name (First, Middle John F. M	•			l	ne (First, Middle, a Kees	Maiden Surname)	
Mary	12 should be file alth and Mental I 27 is marked o ir traumatic eve		19a. Informant's Name/Relation John F. Mur	ship (Type, Print) phy/father		ailing Address (Street  8 Lincol:				
Baltimore,	Page 1 and ment of Hea ant: If item ary or other		20a. Method of Disposition	n 3 ☐ Removal from State (Specify)	20h, Place of Dis	position (Name of rematory or other place le cometo		Date 23/09	20c. Location - Ci	
Balt	permit. Page Department of Important; If any injury or		21. Signature of Funeral Service	Pensee BL		22. Name and Addre			Funera insburg	
	Physician/ Medical Examiner	_	Immediate Cause (Final disease or condition resulting in death)	or complications that caused t only one cause on each line a Due to (or as-	hlor I	nter the mode of dyir An los Lan	g, such as cardiac Sym	or respiratory arr	rest,	Approximate Interval Between Conset and Death
0	cate be executed physician and the burial-transit	Aedical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c	a consequence of):  MG MU  a/consequence of):  MOM (	tei 7	ron	<u>.</u>	*	6 on th
. Box 68760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1	2 Fetal death 3	Ectopic pregnand	су		23d. Date o	·
ls, P.O.	v requires that the second by should be detailed	þ	Part II. Other significant condition	ions contributing to death b	out not resulting in the	e underlying cause gi	ven in Part I.			ute to the cause of death?
of Vital Records,	ician: The law req certificate has bee ector, page 2 shoo	Completed	25. Was case referred to medica	ubitu Mscle	s M	cer	5.	1 🗆 Yes	price	re autopsy findings available or to completion of cause of ath? Yes 2 \( \sum \) No
f Vita		: To Be	examiner? 1 Yes 2 No  27. Manner eath	Hospital:	ent 2 ER/Outpat	ient 3 DOA Oth	14 Nursing F	lome 5 Resid	dence 6 Other (	Specify)
Division o	tending death. stor: After the funer	Certificate:	1 atural 5 Pend 2 Accident Inves 3 Suicide 6 Coul	ling (Month, Day	y, Year) injury	/ work			ow injury occurred	
Divis	pital or A			mined building, etc				City or Tow	n, State)	or Rural Route Number,
	To the Hospital or Attending Physwithin 24 hours after death.  To the Funeral Director: After this completed filled in by the funeral di	Medical	(Ch¢ck/ 2 <u>U</u> Medical	ng Nurse Practioner: To the	xamination and/or inv	estigation, in my opinio	on, death occurred e time, date and pla	at the time, date as ace, and due to the	nd place, and due to e cause(s) and mann	the cause(s) and manner stated. er as stated.
	3		▶ Nea	MO		20	04503	1 -	29d. Date signed (N	21 200°9.
_	4		30. Name and address of person	- 81DD7Q	er :	Print) NYE	antic	Hau	St Hav	8 ND 27748
	Stat Registra		31. Date filed (Month, Day, Year)	2009 32 Registra	ar's Signature	ad			(	/

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State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 30 M Elmer McAllister Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Washington Hagerstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral March 7,1933 Hours Company land 1**XX**M 2 □ F Director 217-32-7454 76 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 Yes 2 XNo Maryland Washington Big Spring 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral USA 11434 Charles Mill Road 21722 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1 Yes 2 ANo
If Yes, Give Black White etc. þ 1 Never Married 2 X Married 1 Yes 2 No Specify Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Mason Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည McAllister Lida Shank Herbert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16612 Coney Court Williamsport, Maryland 21795 Dorothy J. McAllister-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Busien Crema 4 Donation 5 🗌 Othe Rose Hill Cemetery Sept.25,2009 Clear Spring, Maryland Osborned Funerall Home, P.A. ature of Fu neral 425 S. Conococheague St. Williamsport, MD 21795 art +: Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final -€πysiciaπ/ disease or condition resulting in death) Medical Due to (or as a consequence of Examine Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown g 🗌 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed t ģ 3 Probably 4 Unknown Vital Records, 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has perform 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 은 ER/Outpatient 3 🗌 DOA 1 Inpatient 2 After this o cempleted filled in by the funeral 28b. Time of 27. Manper of Death 28a. Date of injury 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Division 2 Accident
3 Suicide
4 Homicide Investigation Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined To the Funeral L Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Contifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Dav. Year) 29b. Signature and file of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $r^{\text{Day}}17 2009$ Physician September 2:47 A James P. Murphy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Worcester Atlantic General Hospital Berlin If Under 1 Year | If Under 24 Hrs. 8. Date of Birth | Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Hours 1 □XM 2 □ F 108-42-0765 12/04/1949 NY 59 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 ☑ No Director MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 9 Hudson Place 21811 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∏Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2X ☐ No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Town of Oyster Bay deputy comptroller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Philomena Bozzella James P. Murphy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lorraine Murphy (Wife) 9 Hudson Place Berlin MD 21811 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Locust Valley Cem. Locust Valley, NY 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Devine Funeral Home 293 South St. Oyster Bay, NY 23a. Part 1/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) oan Due to (or as a consequence of): Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 4 Unknown 1 ☐ Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an mellitu autopsy 2 **W**No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 11No 1 🗌 Yes ို Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work?

certificate be executed P.O. Box 68760,

**Funeral** 

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Everrings must be notified at

and Mental Hygiene. is marked other than "

permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any injury or other traumatic evonce. Pages 1 and 2 should be

**Physician** 

/Medical

Examiner

filed within 72 hours after death

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be entitled 24 within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial Division of Vital Records,

DH 12

DHMH 17 Rev 1/2001

State Registrar

Medical

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

1 ☐ Yes 2 ☐ No

29d. Date signed (Monthy Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ua Jr. N 32. Registrar's Signature Hothony

31. Date filed (Month, Day, Year)

5 Pending investigation

6 Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** c Caule 5:45 AM tember 20 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sanctuary at Holy Cross Burtonsville Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 □ M 2 🗓 F Director 257-07-1633 December 21,1916 92 Georgia Usual Residence of Decedent 10c, City, Town or Location 10a. State 10b. County 10d. Inside City Limits show ns 23a or 28a-f shov must be notifled at 1 ☐ Yes 2KINo Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death vernent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23: ury or other traumatic event, the Medical Examiner must Completed by Funeral 1809 Billman Lane 20902 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 □ Never Married 2 □ Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify 3 ☑ Widowed 4 ☐ Divorced Year or Dates African-American 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Contract Specialist U.S. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Henry Borders Willie Belle Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anita E. Henderson - Daughter 1809 Billman Lane, Silver Spring, Maryland 20902 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of H Important: If ite any Injury or ot 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory 09/25/2009 Brentwood, Marvland 21. Signature of Funeral Service Licensee MO#1070 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate se (Final disease or condition resulting in death) Stay Dementa Physician End 2 /Medical Due to (or as a conse mance of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physiciar Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒ No 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy for Day 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by reas 1 Tyes 2 No 3 Probably 4 ☐ Unknown per 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the f 2 Accident 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29c. License number Cectifier 29d. Date signed (Month, Day, Year) 29b. Signature a D6053337 0 30. Name and address of person who completed cause of death (Item 23a) (Type Print)
Dorothy Secry, no 25 Main Street Suite 200 Reisterstown, Md 21136 Jean 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

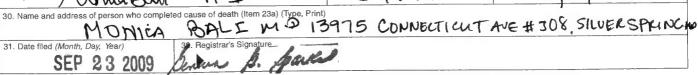
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 21, 2009 6:00 a M **Physician** Ruth Martin /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Rockville 14123 Canterbury Lane 8. Date of Birth (Month, Day, Year)
July 17, 1 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2**\*□**¥F 1919 Panama 213-90-7346 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County or than "natural", or items 23a or 28a-f show the Medical Exprimer must be multiped at 1 ☐ Yes 2 No Director Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20853 14123 Canterbury Lane Funeral within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐Yes 2 XNo If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ∐Yes 2 XXNo Specify: ð 3 XWidowed 4 ☐ Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) les 1 and 2 should be filed within of Health and Mental Hygiene. If item 27 is marked other than "or other traumatic event, Inc. Mex. Elementary/Secondary (0-12) College (1-4or 5+) Garment Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia A. Waite Stephen Dick ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 14123 Canterbury Lane, Rockville, MD 20853 Alene Mills/Daughter 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1 Department of H Important: If ite any Injury or ot Sept. 2009 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Francis J. Collins Funeral Home
500 University Blvd. W., Silver 21. Signature of Funeral Service Licensee Inc. Spring, MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached f ☐Yes 2 ☑No 9 Unknown 9 T Hinknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No dis soc 2 No 1 ☐ Yes 1 ☐ Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director Be Other: 4 Nursing Home 5X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To this funeral 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) After To the Hospital or Attentums
Within 24 hours after death.
To the Funeral Director: After the funeral in the fun 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b, Signature and title of certifier 21/09

State Registrar

31. Date filed (Month, Day, Year) 23



DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPTEMBER 20 2009 **Physician** 11:38AM MITCHELL SHIRLEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S PRINCE GEORGE'S HOSPITAL CHEVERLY If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9/5/1934 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Days 1 ☐ M 2 🛣 F MARYLAND Yrs. Director 216-30**-**2577 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "neturel", or Iteme 23a or 28a-f ehow the Medical Examiner must be notified at 1√ Yes 2 No Director PRINCE GEORGE'S CAPITOL HEIGHTS 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 USA 315 YORK KNOLLS DRIVE Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔯 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 10 Specify: BLACK Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify. þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE HOUSEWIFE 12TH permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If tem 27 is marked other any liqury or other traumatic event, SDE. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be HATTIE **JAMES** ISAAC HENRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 19a. Informant's Name/Relationship (Type, Print) LEONE MITCHELL SR./HUSBAND 315 YORK KNOLLS DRIVE CAPITOL HEIGHTS, MARYLAND 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/28/2009 RIVERDALE, MARYLAND RIVERDALE CREMATORY J. B. JENKINS FUNERAL HOME 21. Signature of Huneral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CARDIAC ARRHYTHMIA /Medical Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CORONARY ARTERY DISEASE Due to (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2√ No 9 ☐ Unknown the 9 Unknown δ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? SEPSIS 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown RENAL FAILURE 24b. Were autopsy findings available prior to completion of cause of death? 

1 ☐ Yes 2 No 24a. Was an hes autopsy performed? (es 2 ☑-No RESPIRATORY FAILURE 1 🗆 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐XNo 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA şi Ç s efter death. if Director: After this od in by the funeral d 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Medical 29a. Certifier 1 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D16278 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20785 6130 LANDOVER ROAD CHEVERLY, MARYLAND REVATHY MURTHY M.D. 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

3. Time of Death

01

1 ☐ Yes 2X No

Approximate Interval Between Onset and Death

hours

Year

29d. Date signed (Month, Day, Year)

09.

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** estember Dylan Robert McGrath /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Shady Grove Adventist Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 6. Sex Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days **™** M 2□F Yrs. Director 218-85-2785 27 Aug. 28, 2009 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nnert of Health and Mental Hygiene.
and: If item 27 is marked other than "natural", or items 23a or 28a-f show and: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10b. County 10d. Inside City Limits Director Maryland Montgomery Germantown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18834 Sky Blue Circle 20874 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No ģ If Yes, Give Year or Dates: Specify Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -0-Infant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Brian Joseph McGrath Annie O'Boyle 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brian J. Mc Grath - Father 18834 Sky Blue Circle, Germantown, Maryland 20874 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1 Department of F Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Domation 5 ☐ Other (Specify) Metropolitan Crematorium 9/28/09 Alexandria, Virginia 21. Signature of Funeral Service License 22. Name and Address of Facilit Molesworth-Williams P.A., Funeral Home Court 26401 Ridge Road, Damascus, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Severe Necrotising Entero colitis **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-tra Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 4☐Pregnant at time of death 9☐Unknown 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1∏ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28d. Describe how injury occurred Injury at Work? 1 XNatural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. neral Director: , filled in by the f 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

the Hospital or Attending Physician:

Medical

(Check only

29b. Signature and title of certifier

31. Date filed State Registra DHMH 17 Rev 1/2001

30. Name and address of person who completed call

e of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

ADVENTIME HOSPITAL

07445 son Paul Mad	docl	Please Type or Print in Black Indeli State of Maryland / Departme				0001
Physicia		1- For State Registrar 1. Decedent's Name (First, Middle,Last)	ate of Death	2. Date of Dea	eg. No.	3. Time of Death
edical Exami		Jason P. Maddock			Day Year er 23, 2009	0940 hrs
		<ol> <li>Facility Name (if not institution, give street and number)</li> <li>18701 Roxbury Road</li> </ol>	4b. City, Town, or Location Hagerstown	on of Death	4c. County of Death Washington	
Funeral Director		5. Social Security Number 219–94–9990 6. Sex 7. Age (In yrs. last birt 32	· · · · · · · · · · · · · · · · · · ·	nder 24Hrs. 8. Date of Bi ours Min. 02/20	th(MM/DD/YYYY) 9. Birt Foreig /1977 LSU	
w any		Usual Residence of Decedent  10a. State  10b. County  Maryland  Wicomico  De				10d. Inside City Limits  1 Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code		109. Citizen of What Cour	
vith the Maryland s 23a or 28a-f show cnotified at once.		30688 Gordy Mill Rd.  11. Mantal Status 12. Was Decedent Ever in U.S.	21875	Origin? ( Specify Yes or N	USA D- 14. Race - Ameri	can Indian, Black,
r death v or items	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	If Yes, specify Cuban, Mexic	can, Puerto Rican, etc.)	White, etc.	
urs afte tural", aminer	ò	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a.	1 Yes 2 X No spec Decedent's Usual Occupation (Gi		Specify: What 16b. Kind of Business/I	nite ndustry
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland Pages 1 and Anntal Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO No landscaper	OT use retired)	landscapin	na .
215-0036 be filed within 7: ntal Hygiene. rked other than ent, the Medical		17. Father's Name (First, Middle, Last)	18.Mot	ther's Name (First, Middle,	Maiden Surname)	
2121 uld be fi Mental I marked c event,	To Be	Stephen D. Maddock  19a. Informant's Name/Relationship (Type, Print )  19	. Mailing Address (Street and N		olmes	Zin Code)
and 2 shoul lealth and M tem 27 is m traumatic	-	Stephen Maddock/father	14800 Milton B	Brook Ct., Sp	parks, MD 21	152
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygener Important: If item 27 is marked other thinjury or other traumatic event, the Med		Bunal 2 X Cremation 3 Removal from State cremat	of Disposition (Name of cemetery, ory or other place) Dury Crematory	Date 9/25/09	20c. Location - City or Salisbury	
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		4 Ponation 5 Other Specify: 21 Signature of Funeral Service Licensee	22. Name and Address of Face Holloway Fune 501 Snow Hill		ofessional.A	ssociation
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not	a aniamile and alcohological actions of the contract of	as cardiac or respiratory ar	rest, shock, or heart	Approximate Interval
/Medical		failure. List only one cause on each line.  Narcotic intoX  Immediate Cause (Final disease a.	ication			Between Onset and Death
		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.				
	niner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
xecuted n and • - transit	Examine	events resulting in death) Last  Due to (or as a consequence of):				
760, ficate be execu g physician an the burial - tr	dical	X UNPENDED AMENDED 23a,27,28	a-f, perME, G89	6 10/7/09 TT		
x 68 h certi tendin use as	sician/Medi	Pregnant at time of death	Fetal death 3 Ect Other (Specify)	topic pregnancy	23d. Date of deliver Month	y Day Year
J. Bo t the deat by the at ached for	Phys	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resulting	o in the underlying cause given in	n Part I. 23e. Did	tobacco use contribute to	the cause of death?
i, P.C ires that signed is	by			1Y	es 2 No 3 Pro	bably 4 🗸 Unknown
(ecords, The law requir ate has been a	Completed			per		utopsy findings available completion of cause of es 2 No
tal Recian: The certificate ector, page	Be C	25. Was case referred to medical examiner?	Othor	eath (Check only one)		Toponial Control of the Control of t
of Viring Physical After this	င္	1 Yes 2 No Tospital 1 Inpatient 2 ER/C	utpatient 3 DOA Other		Residence 6 Other	r: Scene
ion of tending Pheath.	ation	1 Natural 5 Pending (Month, Day, Year)	9:15 am 1 Yes 2			
Division spital or Attenchours after death ineral Director:	Certification:	3 Suicide 6 X Could not be 28e. Place of Injury - At home, to	arm, street, factory, office building	g, etc. 28f. Location or Town, Inst.	(Street and Number or R State)Roxbury Hagerstown,	ural Route Number, City Correctional MD
To the Hosp within 24 hos To the Fune completely fi	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or				
F > 5	Me	and manner stated.  29b. Signature and title of certifier	29c. License num		29d. Date signed (Mo	
		J.M. te	O.C.M.E.		September 24,	2009
			11 Penn Street, Baltimor	re, MD 21201		
S Regis	tate trar	31. Oate filed (Month Day, Year) Registrar's Signature	park			
		,			00642	

DHMH 17 Rev 1/2001

ORIGINAL

	1	For State Registrar			ı ıvıaryıan		rificate of			Reg. No. 2	09 320	
Physician /Medical	n	1. Decedent's Name (First, M		long Thi	i Nguyen				2. Date of Domination	abor 2	Year 3. Time of Dea	
Examine	r	4a. Facility Name (If not instit	tution, give	street and nur	mber)		4b. City, Town, o	or Location of	Death	4c. County	of Death	
		Doctors Comm	munity	Hospital	l			anham			Prince George's	
neral ector		5. Social Security Number 21.5-35-0808	6. Se:	х ] М 2 <b>Х</b> F	7. Age (In yrs. <b>71</b> .	last birthday) Yrs.	Months Days	If Under 2 Hours	Min. (Month, D	irth Pay, Year) <b>26, 1938</b>	9. Birthplace (State or Fo Country) <b>Vietnam</b>	
		Usual Residence of Deceden										
H .	. !	10a. State 10b. Cou	unty		10c. Cit	y, Town or Loc	ati <i>o</i> n				10d. Inside City Li	
5	용	Maryland Pri	ince Ge	eorge's				Lanham			1 ☐ Yes 2 🕱	
i i	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of V	Vhat Country?	
		6723 Cath	hedral	Avenue				20706			Vietnam	
imporant, in tent of a marked often than hadral continuer in ust be notified at once.  To Be Completed by Funeral Director	<u>`</u>	11. Marital Status  1 □ Never Married 2 👿 1  3 □ Widowed 4 □ Divor	Married	12. Was Dece Armed Fo 1 □Yes If Yes, Giv Year or D	2 🛣 No ve		as Decedent of he Yes, specify Cub		in? (Specify Yes or N Puerto Rican, etc.)	o- 14. Rac Blac Specify	e - American Indian, xk, White, etc.	
Į d	Completed	15. Dece (Specify only hi	edent's Edu	cation		16a. Decede	ent's Usual Occup	pation	of working	16b. Kind of Bu	usiness/Industry	
2	흔	Elementary/Secondary (0-1		College (1	-4or 5+)	life. D	ind of work done O NOT use retire	d)	or working			
ځ	5	12					Laundry W	lorker		La	undry Services	
	Be (	17. Father's Name (First, Mid	ddle, Last)					18. Mother	's Name (First, Middle	e, Maiden Sumam	ne)	
	0	Phuc Ng	guyen						Phuc Nguye	n		
		19a. Informant's Name/Relat	tionship (Ty	rpe. Print)		19b. Mailing	Address (Street	and Number	or Rural Route Numi	ber, City or Town,	State, Zip Code)	
		Anthony Hope	e - Hus	band		6723	Cathedral	Avenue	, Lanham, Ma	ryland 207	06	
	1	20a. Method of Disposition			20b. F	lace of Dispos	tion (Name of atory or other pla		Date	20c. Location -	City or Town, State	
		1 ☐ Burial 2 ☑ Cremati 4 ☐ Donation 5 ☐ Othe			State		nory or other pla Ln Cremato	i	09/26/2009	Brentwo	od, Maryland	
	T	21. Signature of Funeral Sen	-	ene. 11 /						1		
ouce		A		10 # (O)	101	Hi	nes-Rinald	li Funer	al Home, Inc	·	, Maryland 2090	
an cal edical Examiner	ledical Examiner	23a. Part 1. Enter the disease shock of the first failure. Immedia Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	{	Due to (		uence of):	Shoc	wer /	1 A Kuss	5927	Approximate Interval Between Onset and Deat	
Physician/Me		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown		1 🔲 Live b	come of pregna birth 2 Feta nant at time of c own	I death 3 🗌	Ectopic pregnand Other (specify)	су			te of delivery nnth Day Year	
		Part II. Other significant con ASH ma		ntributing to de	eath but not resi	ulting in the und	lerlying cause giv	ven in Part I.		23e. Did tobacco use contribute to the cause of d		
o to	ere	,		Idisn	,				04- 141-	0.00	Mora autono, findings such	
or Attending Physician: The law requires the after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by		11 april 10	9,7	, – (3)					perf	opsy formed?	Were autopsy findings avai prior to completion of cause death? 1 □Yes 2 □No	
	a l	25. Was case referred to med examiner?							of Death (Check only	one)		
2		Yes 2 □ No	1	łospital:	npatient 2	ER/Outpatient	3 □ DOA Oth	ner: 4 □ Nur	sing Home 5 ☐ Res	sidence 6 Oth	ner (Specify)	
l'ë	<u> </u>	27. Manner of Death 1 □ Natural 5 □ Pe	ending	(Mont	of Injury th, Day, Year)	28b. Time of Injury	28c. Inju	ry at rk?	28d. Describe	how injury occurr	red Collapse	
uttending Phys death. ctor: After this y the funeral dir fication: To		1 Natural 5 Pending (Month, Day, Year) Injury Work? 2 Accident investigation September 21, Mes 12, M 1 Yes 2 No 1 Her using harm							0 11718	rising	MAIN dye	
Satio	atio	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)					, farm, street, factory, office  28f. Location (Street and Number or Rural Route Numb City or Town, State)					
ertificatio	eruncado		termineu	Bullan		1) OA			17/12/2	lace, and due to the cause(s) and manner as stated. recurred at the time, date and place, and due to the cause(s)		
edical Certification:		4 ☐ Homicide det	tifying Phy	sician: To the	best of my kno asis of examina ner stated.	wledge, death	occurred at the t	ime, date and opinion, deat	place, and due to th	e cause(s) and ma	anner as stated.	
Medical Certification	edical	4 ☐ Homicide der  29a. Certifier 1 ☐ Certifier (Check only 2 ☐ Medi	tifying Phy lical Exami	sician: To the	asis of examina	wledge, death	occurred at the t	opinion, deat	place, and due to th	e cause(s) and ma e, date and place,	anner as stated.	
lled in by the	edical	4 Homicide del	tifying Phy lical Exami	sician: To the	asis of examina	wledge, death	occurred at the testigation, in my	opinion, deat	d place, and due to the	e cause(s) and ma e, date and place, 29d. Date signer	anner as stated. and due to the cause(s)	

State Registrar 31. Date filed (Month, Day, Year)

SEP 23 2009

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2. Registrar's Signature

		Registrar				Ce	ertifica	te of L	Death			Reg. No		12 12 3
icia	_	1. Decedent's Name (First, Mid			N7.4 - 1						2. Date of Dea	Da		3. Time of Deat 12:30 a
dica	1	Nkechi la. Facility Name (If not institut	Jan		Njol	Ku	4h City	Town or	Location	of Death	Sept.		. County of Deeth	
nine	r	11610 Middleh			ambory				far1b				rince Ge	
al		5. Social Security Number	6. Sex	(		yrs. last birthday	-	r 1 Year	If Under		8. Date of Birt (Month, Da			plece (State or For
or		none	1 [	]M 2⊠F		24 Yrs.	Monins	Days	Hours	IVIIII.	03/30/	1985	Nig	geria
	) <u> </u>	Usual Residence of Decedent 10a, State 10b, Cour	ntv		10	c. City, Town or L	Location							10d. Inside City Lir
	ō	Md. Prin	ice G	eorge		Upper		boro						Maryes 2□
	Director	10e. Street and Number						ip Code					tizen of What Cou	intry?
		11610 Middleh	nam D	rive				20774	ł			N	Vigeria	
	Funeral	11. Marital Status		12. Was De Armed F	orces?	r in U.S. 13	. Was Dece	edent of Hi	ispanic Or in, Mexicai	igin? (Spo	ecrfy Yes or No Rican, etc.)	-	14. Race - Amer Black, White	
	Dy F	1 Never Married 2 M 3 Widowed 4 Divorc		If Yes, G	2 ☑ No Sive		1 🗆 Yes	2√ No	Specify:				Specify:	Black
		15. Deced		Year or	Dates:	16a Dec	edent's Usi	ual Occup	ation			16b K	(ind of Business/I	ndustry
	Completed	(Specify only high	hest grade	e completed		(Giv	e kind of w	ork done d	during mos	t of work	ing			
	E C	Elementary/Secondary (0-12	2)	4	(1-4or 5+)	En	ginee	r				Е	Engineer	ing
	Re	17. Father's Name (First, Middle	le, Last)						18. Moth	er's Name	e (First, Middle,	Maider	Sumame)	
	0	Sabastine Njo	ku						R	ose :	Ifeanyi	chuk	wu Iheag	gwara Njo
		19a. Informant's Name/Relatio	nship (Ty		المدمالة		•					er, City	or Town, State, Zi	ip Code)
	2	Rose Njoku		(MO	ther)	R.			Jes,		Date	200 1	ocation - City or T	Town State
ouce.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Crematio	n 3 □R	Removal fron	n State	cemetery, cri	ematory or	other plac			/2009		aise, Ni	
	00-	' 4 □ Donation 5 □ Other 21 Sign ture o Funeral erv	-			Family (	22. Name a				772009	TID	arse, Nr	50114
physicia the bur			- 44			integripance off:								
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A CONTRACTOR OF THE PROPERTY O	ledical Certification: To Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown  Part II. Other significant condes and in the cast of the condes and investigation of the cast of the condes and investigation of the co	litions considered by the state of the state	Due to Du	o (or as a co	onsequence of): onsequence of): onsequence of): oregnancy Fetal death 3 e of death 5 ot resulting in the  2 □ ER/Outpatic ani) 28b. Time Injury At home, farm, s	Other (s	cause give	26. Placer: 4 N y at k? Yes 2 Ne, date an pinion, de:	e of Deat ursing Ho	24a. Was auto perfc 1 Yes th (Check only come 1 Hesi 28d. Describe 28f. Location (City or Total and due to the	yes 2 an psy prmed? 2(1) No ong) dence how inju Street a wn, Stat cause(: date an	Month  use contribute to  No 3 Pro  Were au prior to c death? 1 Yes  6 Other (Spec ury occurred  and Number or Ru e)	the cause of death obably 4 Unkilopsy findings avail ompletion of caus 2 No oral Route Number stated.
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	Medical Certification: 10 Be Completed by Physician/Medical	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	diffigure of the second of the	Due to Du	o (or as a co	onsequence of): onsequence of): onsequence of): onsequence of): oregnancy   Fetal death	of Other (s	cause give	26. Placer: 4 N y at k? Yes 2 Nee, date a pinion, de:	e of Deat ursing Ho No No nd place, ath occur	24a. Was autoperficient of the control of the contr	an psy ormed? 21 Noong) dence how inju	Month  use contribute to  No 3   Property of the prior to contribute to the	the cause of deat bably 4 Unk topsy findings avaing letter of cause 2 No safety)  well Route Number stated. to the cause(s)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) Date of Death Month 3. Time of Death Day **Physician** 5:35 P M Anne Friedman Naimark September 17, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 10649 Montrose Avenue #102 Bethesda Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days 1 ☐ M 2 🛛 F Yrs. Feb 5, Director 94 1915 New York 128-05-0340 Usual Residence of Decedent ss 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.

Item 27 is marked other than "nothers". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at Director 1 Yes 2 No MD Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10649 Montrose Avenue #102 Funeral 20814 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: Specify: White δ 1 ☐ Yes 2 No 3X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 Is marked any light or other traumatic evone. Harry Friedman ٥ Rose Freeman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Naimark/daughter 11315 Commonwealth Drive #102 Rockville, MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 09/19/09 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, MD 21. Signature of Funeral Service License Colingan Homes Cremation Service P.O. Box 784 MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death 2 years shock, or heart failure. List only one cause on each line Immediate Cause (Final Non Small Cell Lung Cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Lifer to declying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) spital or Attending Physician: The law requires that the death certificate be executed ours after death.

The law series death.

The law series be executed by the attending physician and filled in by the funered director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ ★Jo 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Ves 2 No 2 □No 1 TYes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 6 □ Other (Specify) 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours af To the Funeral DI 29a. Certifier 1 🖄 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D22775 September 18, 2009

50

Baltimore, Maryland 21215-0036

Box 68760.

P.O.

Division of Vital Records,

State Registrar Frederick G.

31. Date filed (Month, Day, Year)

M.D. 5454 Wisconsin Avenue #1300 Chevy Chase, MD 20815

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Redistrar's Signature

Barr,

SEP 2 2 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 16 2009 4:00 AM Wilbur Jerome O'Neill September /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 319 Hollyberry Road Severna Park Anne Arunel 8. Date of Birth (Month, Pay) (ear) 07/23/1926 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** Days Min. Months Hours 1 XM 2 □ F 031 14 0635 83 Massachusetts Director Usual Residence of Decedent show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shorevent, Included Examinating to redified at Anne Arundel 1 ☐ Yes 2 No Director Severna Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 319 Hollyberry Road 21146 USA Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 △Yes 2 □ NewWII Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Divling and Mechanical
Engineering Designer 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Diving Industry permit. Pages 1 and 2 should be flik Department of Health and Mental H, Important: If item 27 is marked oth any injury or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Michael O'Neill Neva Bressler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 319 Hollyberry Road/Severna Park MD 21146 David O'Neill (son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 9/18/09 Alexandria VA 4 Donation 5 Dother (Specify) 21. Signature of Fanaral Service Licenses 22. Name and Address of Facility
Advent Funeral and Cremation Services Marymawai Annapolis MD and Falls Church VA 23a. Part1. Enter the disease, or complicitif ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 140601 /Medical Due to ( as a consequence of) Examiner Sequentially list conditions, Duri to (or as a consequence of) if any, leading to immediacause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed physician and s the burial-transit Due to (or as a consequence of) Box 68760. Physician/Medical as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy for Month Day Year 4 Pregnant at time of death 5 Other (specify) ned by the 1∐Yes 2 Wo Ö 9 Unknown 9 Unknown signed by to ٣. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy page of Vital 2 No 1 ☐ Yes Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA After this Certification: To in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide Hospital or completely filled 24 hours a 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only the 29b. Signature and title of certifie 2 29c, License number 29d. Date signed (Month, Day, Year)

Sharm M. Messics 31. Date filed (Month, Day, State Registrar

Bon Field Rd, Suite 8, Severna 32. Registrar's Signature

who completed cause of death (Item 23a) (Type, Print)

(MI

**ORIGINAL** 

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Pagistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar #5,9/21/09, per F. Home, D. H. Certificate of Death WCHD 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Wayne Rann 09 13 2009 1:05 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Atlantic General Hospital Berlin Worcester 8. Date of Birth (Month, Day, Year) 07/06/1949 Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday 175-38-2022 **Funeral 1**∕ M 2 □ F Months Days Hours Min 60 PA Director 900-03-6786 Usual Residence of Decedent the Maryland 10d. Inside City Limits 28a-f show 10a State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Director PΑ Delaware Norwood 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ns 23a or 2 126 Henderson Ave 19074 USA Funeral Pages 1 and 2 should be filed within 72 hours after death vent of Health and Mental Hygiene.
Int: If item 27 Is marked other than "natural", or items 23.
Int: My or other traumatic event, In Wedfort Exprime mutary or other traumatic event, In Wedfort Exprime muta 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White Completed by 1 □Yes 2√□No Specify 3 Widowed 4 Divorced 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) sheet metal worker Boeing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Edward Rann Katherine Bleyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Barbara Rann (wife)</u> 126 Henderson Ave Norwood, PA 19074 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cavanagh Crem. Services 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2√☐ Cremation 3 ☐ Removal from State 9/19/2009 Media. PA permit. Page Department ( Important: If any Injury or 5 ☐ Other (Specify) 4 Donation 22. Name and Address of FacilityThe Burbage Funeral Home 21. Signatury of Funeral Service 108 William St. Berlin, MD 21811 Approximate Interval Between Onset and Death 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** a. Asphyxiation ue o (or as a consequence of): disease or condition resulting in death) /Medical Examiner hanging
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Understood Cause (Disease or Injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Year Day 5 Other (specify) P.0. 1 □Yes 2 □No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autopsy perforn this certificate 1 ☐ Yes 2 X No 1 ☐Yes 2 ☐No To the Hospital or Attending Physician: 'within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1[XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 9/13/09 12 M 1 ☐ Yes 2 ☐ No 2 Accident hanging 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Crystal Beach Hotel 25th St Ocean City, MD 21842 To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifie

ET 15

State Registrar d54)

30. Name and address

of person who completed cause of death (Item 23a) (Type, Print)

203 SNOWST, SNOWHILL, MD 21863

		,	For State State Registrar	of Maryland		artment of F tificate of D			giene Reg. No. 200	9 92020
	Physicia	ın/	1. Decedent's Name (First, Middle, Last)  Lucille M.		Reede			2. Date of Dear	23 200°	3. Time of Death 6:40 A M
	Medic \ Examin		4a. Facility Name (if not institution, give street and no	ımber)	Keede		Location of Death		4c. County of Dea	
- ~	) LXGIIIII		Washington County Hos	pital		Hagersto			Washing	
	Funeral Director		5. Social Security Number 220-28-8519  Usual Residence of Decedent	7. Age (In yrs. last	birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 10 2	Year) C	nthplace (State or Foreign country) agerstown, MD
	f show	tor	10a. State 10b. County	10c. City, 7	Town or Loc	ation				10d. Inside City Limits
	Many 28a-	Director	PA Franklin	Gree	encast		<u>-</u>			1 ☐ Yes 2X No
	ith the	ral	10e. Street and Number 1430 Shank Church			10f. Zip Code 17225			10g. Citizen of What C	ountry?
	items	Funeral	11. Marital Status 12. Was De	cedent Ever in U.S.	13. W	Vas Decedent of His	spanic Origin? (Spen n, Mexican, Puerto I	cify Yes or No-	14. Race - Am	
9000	e filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ted by	3 Widowed 4 Divorced If Yes, G			Yes 2 No		noun, otoly	Black, Whi	white
15-	72 ho n "nat	Completed	15. Decedent's Education (Specify only highest grade complete	d)	(Give k	ent's Usual Occupa ind of work done d O NOT use retired)	ation uring most of workir	ng	16b. Kind of Business	s Industry
212	led within Hygiene. other thar ent, the N		Elementary/Seconday (0-12) College	(1-4 or 5+)	homen	,			own home	
pu	filed valued by all Hyg	Be C	17. Father's Name (First, Middle, Last)	<u>'</u>			18. Mother's Name	(First, Middle, N	Maiden Surname)	
yla	should be file and Mental I <b>7 is marked o</b> <b>raumatic eve</b>	욘	George Moats				Ethel Ba	rnes		
Mar	of Health and Ments of Health and Ments fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type, Print)  Donald J. Reeder/spouse			g Address (Street a Shank Ch			City or Town, State, Z	ip Code) 17225
ē,	I and I Healt		20a. Method of Disposition	20b. Plac	ce of Dispos	sition (Name of			astle, PA	
Baltimore, Maryland 21215-0036	Page nent ant: I ury o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State cerr	erland	atory or other place  i Valley	Crematori	.um	20c. Location - City o 2009 Waynesboro	, PA
Bal	permit. Departi Import any inji		21. Signature of Funeral Service Licensee	J		Name and Addres			wersox Fur encastle, E	
			23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on	each line.				15011		Approximate Interval Between
	Pnysician/ Medical	N	Immediate Cause (Final disease or condition resulting in death)	lensive	Sm	08 11E	wel is	chen	lia	Onset and Death
~	Examiner		Due to	o (or as a consequen	ice of):					
		iner	Sequentially list conditions, it any leading to immediate cause. Enter Underlying	or as a consequen	ice off:					
	cuted ind transit	xam	Cause (Disease or linjury that initiated events c.					<u></u>		
0	cate be executed physician and s the burial-transi	edical Examiner	resulting in death) Last Due to	o (or as a consequen	ice oi):					
			- a							
. Box 68	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	in the past 12 months?	utcome of pregnancy e Birth 2	eath 3 🗌	Ectopic pregnancy Other (specify)	/		23d. Date of de Month	blivery Day Year
. P.O.	s that the gned by be deta	by Pi	Part II. Other significant conditions contributing to		_		2 2		bacco use contribute t	
rds	v require been si should	eted	Diobets mellips morbid obesit	, 114	745	rense f	alur,			Probably 4 🗌 Unknown
Division of Vital Records,	sician: The law r certificate has b lirector, page 2 sl	Completed by	Morbid obesit	7				24a. Was a autops perfori	med? prior to death?	
al R	an: Th tificat tor, pa	Be Co	25. Was case referred to medical			26. Pla	ce of Death (Check		2 ☐ No 1 ☐ Ye	s 2 No
Σ,	hysici nis cer I direc	To B	examiner? 1 Yes 2 No Hospital:	Inpatient 2 LE	₹/Outpatient	Othe	r·		ence 6 Other (Spe	cify)
οl	ling P	ate:	1 ☐ Natural 5 ☐ Pending (Mo	e of injury onth, Day, Year)	Bb. Time of injury	28c. Injury work?	_	8d. Describe ho	w injury occurred	
sior	Attenc death ctor: / y the	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be	e of Injury - At home	e farm stre		Yes 2 □ No	28f Location /St	reet and Number or Ru	ural Pouta Number
Θ	al or / s after il Dire			ding, etc. (Specify)	-1	,,,		City or Town		Ta Floate Nambol,
	To the Hospital or Attending Physician: The la within 24 hours after death.  To the Funeral Director: After this certificate ha completed filled in by the funeral director, page?	Medical	29a. Certifier 1 Certifying Physician: To the (Check 2 Medical Examiner: On the b	asis of examination ar	nd/or investi	gation, in my opinior	n, death occurred at	the time, date an	d place, and due to the	cause(s) and manner stated.
	o the vithin of the comple	Σ	only one) 3 Certifying Nurse Practionel 29b. Signature and title of certifier	: To the best of my kr	nowledge, de	29c. License	number	2	9d. Date signed (Mont	h, Dav, Year)
	ds		on second			DGZ	588		Septembe	23rd, 2009
_	7		30. Name and address of person who completed ca	251 6. A	ntic	tum St	Hagers	hown	70	
	Stat Registra	e ar	31. Date filed (Month, Day, Year) 32. SEP 2 4 2009 32.	Degistrar's Signature		40				

DHMH 17 Rev 7/2009

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20, Dorothy May Reinoehl Sept 2009 9:15 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Villa Rosa Nursing Home Mitchellville Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months 1 □ M 2 🗙 F 86 Director 577-26-0827 5/24/1923 MD Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits The marked other than "natural", or items 23a or 288-f show traumatic event, the Medical Evanture russ be notified at Director Tracy's Landing 1XIYes 2∏No Anne Arundel MD filed within 72 hours after death with the Hygiene. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 524 Ark Haven Road 20779 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify þ Specify: White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If Item 27 is marked othany Injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ Charles Stephenson Harriet Richards 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12505 Kilborne Ln., Bowie, MD 20715

ace of Disposition (Name of Date 20c. Location - City or Town, State Richard Reinoehl/Son Baltimore, 1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Memorial Gdns. 9/25/09 Dunkirk, MD 22. Name and Address of Facility Raymond-Wood F.H., 21. Signature of Fameral Service Licensee 00 PO Box 430, Dunkirk, MD 20754 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) 11-01-9 /Medical Due to (a as consequence of): Examiner NOL was reliably list correlations if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Physician; The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O, Box 68760, physician Physician/Medical as attending nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy for 1 in the past 12 months?
1 Yes 2 XNo Month 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes the detached 9 Unknown 9 Unknoy þ signed | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 Wo 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy perform certificate 1 ☐ Yes 2 ☐ No 1 □Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Sursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director; 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatur d title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 732261 09-21-2009 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print) Rd , LANham , MA 20706 Jew) 9500 J.F.e RICHAMO 32. Registra s Signature 31. Date filed (Month, Day, Year) State Registrar 2009 ▶

	1 - State Registrar			Certi	ficate of i	Death		iene eg. No.	100	
cian	Decedent's Name (First, Middentification)		Reich				2. Date of Deat Month		Year	3. Time of Death 3:45 a <sub>M</sub>
lical	As Essilia Name (If not institution				h City Town o	Location of Deat		4c. County		3.43
iner	4a. Facility Name (If not institution			4	b. City, Iown, o		n	4c. County		000
7	1801 E. Jefferson  5. Social Security Number	6. Sex	7. Age (In yrs.	last hirthday)	If Under 1 Year	Rockville If Under 24 Hrs	8. Date of Birth		Montg	onery  blace (State or Foreig
1		1 ☐ M 2 🗷 F		Vrs N	Months Days	Hours Min.	(Month, Day,	Year)	Cour	ntry)
r	131-24-7426 Usual Residence of Decedent		89	9			July 16	, 1920		Germany
	10a. State 10b. County	/	10c. Cit	ty, Town or Locat	tion				1	0d. Inside City Limits
5									1. Yes 2 □ No	
Director	Maryland Mor	tgomery			104 7in Code	Rockville		0g. Citizen of V	What Cour	ntm (2
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Funeral	1801 E. Jefferson Street, Apt. 233					20852		1 =		S.A.
ğ	11. Marital Status	Armed F	orces?	.S.   13. Wa	is Decedent of H es, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or No- to Rican, etc.)		e - A <b>m</b> erio k, White,	can Indian, etc.
βY	1 Never Married 2 Ma	If Yes, G	2. 2█ No ≩ive	1 🗆	Yes 2⊠No	Specify:		Specify	<i>r</i> :	
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ge	17. Father's Name (First, Middle	, Last)				18. Mother's Na	me (First, Middle, I	Maiden Surnam	1e)	
0	Heinrich	Seligmann					Johann	a Hirsch		
	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mailing	Address (Street	and Number or R	ural Route Number	, City or Town,	State, Zip	o Code)
	Rachel Reich Tow	bin - Daugh	ter	11104	4 Hunt Clu	b Drive, 1	Potomac, Ma	ryland 20	0854	
	20a. Method of Disposition		20b. F	Place of Dispositi	ion (Name of		Date	20c. Location -		
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	4 □ Donation 5 □ Other (		/ B	eth El Cer	necery Name and Addre		21/2009	bergen	., r	lew Jersey
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 9-21-2009 **Physician** 1:55PM Helen /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death **Examiner** Washington CJ's Assisted Living Hagerstown, 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 💢 F 85 298-14-8624 Yrs. Director 4-19-1924 Rosedale, WV Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or iteme 23s or 28s-f show or other treumstic event, the Madical Examinar must be notified at 10a. State MD Washington Hagerstown Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21740 U,S,A 145 King Street death Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status be filed within 72 hours after de Ital Hygiene. d other then "natural", or Item 1 ☐ Yes 27 No If Yes, Give Year or Dates: 1 Never Married 2 Married Spec.White Baltimore, Maryland 21215-0036 1 ☐ Yes 12 ☐ No Specify: þ 3 ♥ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker residence 8th grade 0 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Importent: If item 27 is marked oth eny lightly or other treumatic event 2008. 18. Mother's Name (First, Middle, Maiden Sumame) Minnie Ellen Shamblin Boyd Johnson Wright 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11026 National Pike Clear Spring, MD 21722 19a. Informant's Name/Relationship (Type, Print) Linda L. Staubs Date 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a Method of Disposition 24 Little Rose Hill Sept. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Clear Spring, MD 2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Donald Edwin Thomson Funeral Home, Donald Edwin Thomson Funeral Home,
P.O.BOX 310 Clear Spring, MD 21722

Approshock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Neumonia /Medical Due to (or as a consequence of) Examiner iabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner ettending physicien and for use as the burial-transit The law requires that the death certificate be executed 140 stic that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 emen Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached to 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate 1□ Yes 2□No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 ursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifie Lectifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H58258 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 324 E. Antietam St. Hagerstown, MD Shranatan. Do 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State of Maryl State of Maryl State of Maryl State Hegistrar WCHD/SH 9/29/09 per FH Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2009 **Physician** 3:20pm John Milton Shriver /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Somerford Place Washington Hagerstown If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number Birthplace (State or Foreign Country) 7, Age (In vrs. last birthday) **Funeral** 1**⊠**M 2□ F Min. <del>217-18-1923</del> 86 Director Yrs 02/12/1923 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r items 23a or 28a-f show 1 ∏Yes 2 No Director MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 17601 Meadowood Drive 21740 US Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 🔀 No Specify White traumatic event, the Medical Evarþ If Yes, Give Year or Dates: 3 Nidowed 4 Divorced natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Railroad Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Department of Health and Mental I Important: If item 27 Is marked of any Injury or other traumatic eve once. Harry Raymond Shriver Mary Ruth Hedges 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gary Shriver / Son 1948 Oakdale Ave., Green Bay, WI 54302 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematorium | Sept. 22, 2007 SHLUSDUE, ... | 22. Name and Address of Facility Gerald N. Minnich Funeral Home 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** dvance U years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of). P.O. Box 68760, Physician/Medical attending IF FEMALE for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confibute to the cause of death? of Vital Records, 2 3 Probably 4 ☐ Unknown 2 19 No 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

 1 □ Yes
 2 □ No 24a. Was an this certificate has The performe 2 No 1 ☐ Yes To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 (No 1 ☐ Yeş 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ filled in by the funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death Jo the Funeral Director: 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Robe

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month,

, Day,

**SEP 24** 

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 9:00 PM Lillian Smallwood SEP 2009 Sara 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death HESP TAL LEVINDALE Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days 1 ☐ M 2 💢 F Yrs. 579-20-5687 87 6-25-1922 Mary I and Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 🕱 No MD Calvert. Huntingtown 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 3251 Carroll Road 20639 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Mamed 1 ☐ Yes 2 🛣 No Specify. 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles William Garland Sevmour Estella Flora Gibson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard C. Smallwood II, son 3221 Carroll Road, Huntingtown, MD 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Metropolitan Crematory 9-26-2009 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee Wellion 8325 Mt. Harmony Lane, Owings, MD 20736 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ARTERY DISEASE ORDNARY disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 23e. Did tohacco use contribute to the cause of death?

**Physician** /Medical **Examiner** 

**Physician** 

/Medical

Examiner

Director

Funeral

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Be Completed

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lujury or other traumatic event, the Medical Examiner must be notified at once.

3altimore, Maryland 21215-0036

Examiner lical

and burial-tra physician the use as To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica

The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

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Be C	25

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Medical

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rt II. Other significant conditions co	ntributing to death but not resulting in the underlying cause given in Part I.	
RES PIRATORY	FAILURE	

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	1 □ Yes 2 □	]No 3∏7F	robably	4 □Unknowr
	24a. Was an autopsy performed? 1 Yes 2 No	death?		ndings available on of cause of

Was case referr	ed to medical	L					26.	Place of Dea	ath (Check only one)		
examiner? 1 ☐ Yes 2 <b>[X</b> (1	lo lo	Hospital: 1 Impatien	t 2 🗆	ER/Outpatient	3 🗆 [	OOA Oth	er: 4	☐ Nursing H	lome 5 Residence 6	Other (Specify)	
Manner of Death 1. XXNatural 2. Accident	5 Pending investigation			28b. Time of Injury	М	28c. Injur Wor 1 □		2 🗆 No	28d. Describe how injury	occurred	
3□ Suicide 4□ Homicide	6 ☐ Could not be determined		y - At ho <i>(Specif</i> )	ome, farm, stree y)	t, facto	ory, office			28f. Location (Street and City or Town, State)	Number or Rural Route N	umber,

1 X Natural 2   Accident	5 Pending investigation	(Month, Day Year)	Injury M	Work? 1 ☐ Yes	2 🗆 No	250. Describe now rightly occurred
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injury - At he building, etc. (Specit	ome, farm, street, factory)	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)
29a. Certifier (Check only	1 Certifying Physi	cian: To the best of my kno	owledge, death occurre	ed at the time, d	ate and place	e, and due to the cause(s) and manner as stated.

29a. Certifier (Check only one)	1 ★Certifying Physician: To the best of my knowledge, death occ 2 Medical Examiner: On the basis of examination and/or investigand manner stated.		
20h Cianaturo one	I title of codifier	29c License number	29d Date signed (Month Day Year)

Pairw H. WOUDEHIND 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D0063327 SEPT, ZZ, 2009

BALTIMORE. MD

drw) State

GIZHW WOLDEHIWOT, 31. Date filed (Month, Day, Year)

MD 2434 W. BELVEDERE AVE. 32. Registraris Signature

Registrar

		•	For State Registrar	Cei	rtificate of D		, ,	g. No. 2 () [] 9	32025
	Dhysisi		Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Marvin Paul Stouffe	r			Septembe	er 21, 200	
	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I Hagersto			4c. County of Deat	
	Funeral		Broadmore Senior Living  5. Social Security Number  1 X M 2 F 7. Age (1)  1 X M 2 F 7. Age (1)	In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,		nplace (State or Foreign
	Director		220-26-5891 <sup>1፟<b>∆</b>M 2□ F</sup>	84 Yrs.	Months Days	Hours Min.	Jan. 23	, 1925 Mar	
	2 *		Usual Residence of Decedent  10a. State 10b. County 11	0c. City, Town or Lo	cation				10d. Inside City Limits
	f sho	o		Hagerstow					1 X Yes 2 □ No
	28a-	rect	10e. Street and Number		10f. Zip Code			g. Citizen of What Co	untry?
	liled within 7.2 mouts after beath with the maryland Hygiene. The than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	Funeral Director	1175 Professional Court		21740			U.S.A.	
	rems (	uner	11. Marital Status 12. Was Decedent Eve Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No	er in U.S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origin? (Spon, Mexican, Puerto	ecify Ye's or No- Rican, etc.)	14. Race - Ame Black, White	
36	s and	by F	1 ☐ Never Married 2 ☐ Married If ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1∐Yes 2XXNo	Specify:		Specify:	hite
21215-0036	atural	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupa	tion		6b. Kind of Business/	
215	ie.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done do DO NOT use retired)	uring most of worki		Trucking C	ompany
2	lygien her th nt, the	Co	<u> </u>	Mecha		18. Mother's Name		Trucking C	Oniparry
and	intal H ed otl	Be	17. Father's Name (First, Middle, Last)  Ernest Stouffer		!	Lottie	Kinse Kinse		
Maryland	snould be I and Mental h s marked of sumatic ever	၉	19a. Informant's Name/Relationship (Type. Print)	19b. Mailir	ng Address (Street a	nd Number or Run	al Route Number,	City or Town, State, 2	ip Code)
ž i	and z ealth a n 27 is ner trau		Gale E. Stouffer / Son		51 Mar Roc			town, Mary	
ore.	of He of He fitem roth		20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Removal from State	20b. Place of Dispo cemetery, cres	osition (Name of matory or other place	)		20c. Location - City or	
Ĕ	rages tment of I tant: If ite jury or o		4 □ Donation 5 □ Other (Specify)		Church Co			Boonsboro,	
Baltimore,	permit. rages I and 2 should be little the within 7.2 hours after beath with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funorel Service Licensee	Ba	2. Name and Addres ast-Stauff	s of Facility Ter Funer	al Home,	P.A. onsboro, MI	21713
			23a. Part 1 Enter the disease, or complications the caused the shock, or heart failure. List only one obuse in each line.	e death. Do not en	OUG OLD NE ter the mode of dying	RTIONAL P g, such as cardiac	1 KE BOO or respiratory arre	onsporo, ML est,	Approximate Interval Between
L P	hysician		shock, or heart failure. List only one diuse in each line.  Immediate Cause (Final	. 525.	e	1 7			Onset and Death
	/Medical		disease or condition resulting in death)  a. / Due to (or as a condition or as a con	consequence of):	Ren				
E	xaminer	L	Sequentially list conditions.		allita	7			7
	usit set	Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cauce Unease or yu that initiated events to c.	consequence of):					
	n and al-trar	Exar	that initiated events resulting in death) Last C	consequence of):					
68760,	incare be executed ng physician and as the burial-transit		d						
		Medical	IF FEMALE:						
õ က	attendin for use a	ian/I	23b. Was decedent pregnant 1 Live birth 2	Fetal death 3	Ectopic pregnancy			23d. Date of de Month	ivery Day Year
o j	the a	Physician//	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at til	me of death 5 L	Other (specify)				
σ.	is been signed by the should be detached	by Ph	Part II. Other significant conditions contributing to death but r	not resulting in the u	inderlying cause give	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
g	dulles en sig uld be	ed b	Anemio Parkina	Direct Paris	<u> </u>		1 ☐ Ye	s 2 □ No 3 □ P	robably 4 Inknown
မင္မ	has be	Completed	Carcione Porte				24a. Was ar autops	y prior to	topsy findings available completion of cause of
ر ح	cate h	Con	12-12-12-12-12-12-12-12-12-12-12-12-12-1				perform 1 □ Yes 2	ned? death? 1 ☐ Yes	2 □No
Vital Records, P.O. Box	Attenting rivstcan: The law requires that the death cell clean color. After this certificate has been signed by the attendire by the funeral director, page 2 should be detached for use	Be	25. Was case referred to medical examiner?  Hospital: Hospital:		Othe	26. Place of Deat			INC IZE
<u></u>	eral di	5	27. Manner of Death 28a. Date of Injury	2 ER/Outpatie	nt 3 🗆 DOA	4 LI Nursing Ho	me 5 ☐ Reside 28d. Describe ho	w injury occurred	city) Assisted LIV
<u>.</u>	tending rin leath. tor: After th the funeral	atio	1 ■ Natural 5 □ Pending (Month, Day, 1 2 □ Accident investigation	(ear) Injury		? ∕es 2 □No			
Division of	or Atten after deatl Director: I in by the	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury building, etc.	- At home, farm, str (Specify)	reet, factory, office	100	28f. Location (St. City or Town	reet and Number or R n, State)	ural Route Number,
	urs af eral Di eral Di		200 Contilion 4 Technolistics Dhystology To the heat of	my knowledge dee	th accurred at the tim	no, data and place	and due to the c	ause(s) and manner a	s stated
	Io the Hospital of Atterview within 24 hours after de To the Funeral Directo completely filled in by the	Medical	29a. Certifier  (Check only one)    Check only one)    Certifying Physician: To the best of and the basis of each of the basis of each one one one of the basis of each of the basis of each one of the basis of each of the basis of the basis of each of the basis of	xamination and/or in	nvestigation, in my op	pinion, death occur	red at the time, d	ate and place, and du	e to the cause(s)
	within To the comply	Me	29b. Signature and title of certifier		29c. License			9d. Date signed (Mon.	
7	15		- catt		900	18019		9/21/09	
	5		30. Name and address of person who completed cause of dea	/					
	<i>y</i>		VASAIST DATTA 340 MILL	ST. HX	GERSTOL	SW WR	2174	1)	

Registrar

SEP 2 3 2009

09-07369 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Gregory Eric Smith State of Maryland / Department of Health and Mental Hygiene 2009 32027 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Year September 20, 2009 Smith Medical Examiner Gregory Eric 1241 hrs 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death 2500 Clairmont View Way Silver Spring Montgomery 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min. Director 220-72-7139 Country) M D 1 XM 33 Yrs Oct. 8, 1975 Usual Residence of Decedent 10a, State 10b. County 10d. Inside City Limits 10c, City, Town or Location MD Montgomery Silver 1 X Yes 2 No or 28a-f show or items 23a or 28a-f shormust be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2500 Clairmont View Way 20902 United States Funeral 11. Marital Status 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. African Armed Forces? Never Married 2 X Married Yes 2 X No Widowed f Yes, Give Year Yes 2 X No specify: event, the Medical Examiner Divorced Specify: American þ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Etementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 5+ Realtor Real Estate of Health and Mental Hygiene. 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Robert Smith Shirley Austin Pages 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lanaya Smith / Wife 2500 Clairmont View Way, Silver Spring, MD 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, timore, crematory or other place) 1 X Bunal 2 Cremation 3 Removal from State 9/27/2009 Silver Spring, MD Gate of Heaven Cem. Donation 5 Other Specify. 22. Name and Address of Facility 21. Signature of Funeral Se e Licensee McGuire Funeral Service, Inc. 7400 Georgia Avenue, NW, Washington DC **Physician** Firt I. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line Between Onset and √Medical Death Carbon monoxide intoxication Immediate Cause (Final disease aminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last attending physician and for use as the burial - trans Physician/Medical 23a,PII,2/,28a-f,perME, g896 10///09 TT X UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the for use as Live birth Fetal death 3 Ectopic pregnancy Month Day Year past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown Unknown detached Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. icate has been signed I page 2 should be deta þ Cardiomegaly Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other<sub>4</sub> Nursing Home 5 this 1 Yes Inpatient 2 ER/Outpatient 3 DOA Residence 6 V Other: Scene ဥ After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred subject inhaled auto exhaust Certification: Natural Yes 2 X No Pending fer: Fd 9/20/09 Fd 12:40 X Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number of Rural Route Number, City or Town, State) 2500 Clairmont View Way Silver Spring, MD Could not be Suicide o the Funeral Disputely filled in determined (Specify) Found: residence (garage) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PE

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Ling Li, MD

31. Date filed Mooth, Day Year,

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

OCME

September 21, 2009

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** sept. 16, 2009 Year Leyli Sobhany 0605 Khanom /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery Social Security Number If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 9. Birthplace (State or Foreign 7. Age **Funeral** 219-23-5686 85 Months Days Hours 1 □ M 2 🔀 F Yrs. Director Iran Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner means to relative 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits Ellicott City MD Howard Director 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9008 Town and Country Blvd. 21043 Iran Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 Completed by 1∐Yes 2⊠No Specify: White 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname)
Sanam Ghahremani Be Alahgholy Sobhany 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
703 Colby Avenue Takoma Park, Md. 20912 703 Colby Avenue Golshah Agdasi/Daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Rentoval from State 9/21/2009 Silver Spring, Md. Gate of Heaven 4 ☐ Donation \_ 5 ☐ Other (Specify) 21. Signature of Funeral Service Lic PHILIP D. RINALDI FUNERAL SERVICE, P.A. 23a. Part 1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 9241 Columbia Blvd.Silver Spring, Md20910 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** months Tongue Cancer /Medical Due to (or as a consequence of) Examiner Metastatic Tongue Cancer months Sequentially list conditions, and a light conditions, and a light cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dire to (arids a pensequence of) Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🛣 No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 K No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 1∐Yes 2⊋No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1X Natural 5 Pending investigation within 24 hours after death.

To the Funeral Director: Af
completely filled in by the fun 1 ☐ Yes 2 ☐ No 2 Accident 3 T Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Do not the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) within 2 29d. Date signed (Month, Day, Year) Sept. 17, 2009 29b. Signature and title of certifier 29c. License number D32332 30. Name and addres of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue #220 Silver Spring, Md20902 Suresh K.Gupta M.D. 31. Date filed (Month, Day, Year) . Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

23 2009

P.O.

	1 - For State Registrar			i wai yiai		rtificate of	lealth and M Death		Reg. No.		
hysician /Medical	1. Decedent's Nam Mira		Denise	Sumb1	in			2. Date of Dea Month Sept. 1	Day 200	9 Year	3. Time of Death 11:58 P M
xaminer	4a, Facility Name	(If not institution,	give street and nu	imber)		4b. City, Town, o	r Location of Death		4c. Coun	ty of Death	
	Hospi	ce of th	ne Chesap	eake		Harwo	ood		Anne	Arun	del.
neral ector	5. Social Security 250-04-		6. Sex 1 ☐ M 2 🔀 F	7. Age (In yrs. 54	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Day 09/29/1	h /. Year) 954	9. Birth Cou S •	place (State or Foreign ntry) C •
,	Usual Residence										
fied at	10a. State Md •	10b. County Prince	e Georges		y, Town or Lo Temple						10d. Inside City Limits 1   Yes 2   No
ie e	10e. Street and No	umber				10f. Zip Code			10g. Citizen of What Country?		
	2016 Ga	aither S	Street	√ 3     √ 3		20748	}		U.S.	Α.	
Transite notified	11. Marital Status	rried 2 🛭 Marri	Armed F	edent Ever in U	.S. 13.	Was Decedent of H If Yes, specify Cub	dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No- Rican, etc.)	14. Ra Bl	ice - Ameri ack, White	can Indian, etc.
Example 1 by F		4 Divorced	If Yes, G Year or [	ive		1□Yes 2⊠tNo	Specify:		Spec	ity: B1	ack
etec	(Spe	15. Decedent	's Education t grade completed		16a. Dece	dent's Usual Occup	pation during most of world)	kina	16b. Kind of	Business/Ir	ndustry
t, the Medical I	Elementary/Sec		1	1-4or 5+)	Con	DO NOT use retired tract Spe	cialist		Gov '	t Con	tractor
Important: It is the first and the first in the Medical Examiner must be notified at page.  Doca.  To Be Completed by Funeral Director	17. Father's Name Herbert	(First, Middle, I Sawyer	Last)				18. Mother's Nam Joyne1	ne (First, Middle, 1a Ho1me		me)	
	19a. Informant's N	Name/Relationsh	nip (Type, Print)		19b. Maili	ng Address (Street	and Number or Ru	ral Route Numbe	r, City or Tow	n, State, Zi	p Code)
rtra	Garry	M. Sumb	lin (Hu	sband)	2016	Gaither	Street	Temple	Hills.	Md.	20748
oth	20a. Method of Dis	,			lace of Dispo	sition (Name of matory or other plan	cel	Date	20c. Location		own, State
ry or		Cremation 5 □ Sther Sp	3 Removal from	State		Veterans	109/2	5/2009	Chelt.	enham	, Md.

**Physician** /Medical **Examiner** 

Baltimore, Maryland 21215-0036

Examiner

attending physician and for use as the burial-tran Be Completed by Physiclan/Medical detached been signed by should be detact certificate has page 2 director 2 within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral of

The law requires that the death certificate be executed

To the Hospital or Attending

Division of Vital Records, P.O. Box 68760,

IF FEMALE

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

9 Unknown

in the past 12 months?

25. Was case referred to medical

5 Pending

investigation

1 Yes 2 No

examiner?

27. Manner of Death

1 Natural

29a. Certifier

2 Accident

> 23c. If yes, outcome of pregnancy
> 1 ☐ Live birth 2 ☐ Fetal death 4☐ Pregnant at time of death

9 Unknown

Breast

Due to (or as a consequence of)

Due to (or as a consequence of)

Due to (or as a consequence of)

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

ancer

3 DEctopic pregnancy 5 Other (specify)

3□ DOA

2 ER/Outpatient

28b. Time of

Injury

23d. Date of delivery Day Month

23e. Did tobacco use contribute to the cause of death?

2 XVo

Year

Approximate Interval Between Onset and Death

years

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

24a. Was an autopsy performed? 1 ☐ Yes 2€ No

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2√2 No

3 Probably 4 Unknown

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify)HOSpice 28d. Describe how injury occurred

6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certified

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

Maryland Veterans 09/25/2009 Cheltens

What and Address of Facility

W. H. Bacon Funeral Home, Inc.

3447 14th Street, N.W. Washington,

29d. Date signed (Month, Day, Year) 200

30. Name and address of person cause of death (Item 23a) (Type, Print)

D0068056 Kaiser Permanente-Largo Center 1221 Mercantile Ln. Largo, Md.

20774

State Registrar

Medical Certification:

SEP 2 3 2009

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*ffenroth* 32. Registrar's

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 16, Year 2009 8:22 P<sub>M</sub> Spencer **Physician** Wayne /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Tyaskin 22011 Nanticoke Road If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 05/09/1945 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Maryland Months **№** M 2□ F 64 219-42-8085 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Exeminations to moltified at 1 ☐ Yes 2 X No Tyaskin Director Maryland Wicomico 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number within 72 hours after death with 21865 USA 22011 Nanticoke Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white ð 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) law enforcement police officer Pages 1 and 2 should be filed v nent of Health and Mental Hygie ant: If item 27 is marked other i 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Cordrey Charles Spencer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
22011 Nanticoke Rd., Tyaskin, MD 21865 19a. Informant's Name/Relationship (Type. Print)
Myra Spencer/spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iten
any Injury or ott 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/21/09 Oak Grove Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. it is the of Funeral Service Licenses david H. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Metastatic 400 **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the death certificate be executed use as the burial-transi and Due to (or as a consequence of). physician P.O. Box 68760 Physician/Medical signed by the attending part be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy performe 2 **N**No 2 ☐ No 1 ☐ Yes funeral director, 26. Place of Death (Check only one) Be 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Hospital or Attending P 24 hours after death. Funeral Director; After t 5 Pending investigation Injury 1 Natural 2 Accident 1 ☐ Yes 2 ☐ No filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a X Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and prepriner stated. completely (Check only one) To the l 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier NO. 030690 30. Name and address of person w completed cause of death (Item 23a) (Type, Print) 100 E. Carroll St. Solisbury MD

State Registrar

IN E. MURT 31. Date filed (Month, Day, Year) SEP 22 32. Pegistrar's Signature

M.0

Physician

/Medical

Examiner

Director

Be Completed by Funeral

2

Examiner

Be Completed by Physician/Medical

Medical Certification: To

**Funeral** 

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person w o completed cause of death (Item 23a) (Type, Print)

2 2 2009

For State Registrar		_					Health <i>Death</i>			Reg.	115	1110	3	203
Decedent's Name (First, Midd		Sand	ers						2. Date of Month Sept		r 15,	, 200		me of Death 2:16 PM
Facility Name (If not institution 14179 Carver					4b. C	Eden	or Location	of Death			4c. Count	nty of Dea		
Social Security Number 235–50–7297	6. Sex 1  M 2  F			ast birthda Yrs	Mont	nder 1 Year ths Days		r 24 Hrs. Min.		f Birth n, Day, Ye. 29/19		C	ountry)	itate or Foreig
ual Residence of Decedent			100 0"	, Town or	Locati				/ 2					ide City Limits
a. State 10b. Count	erset		_	len	Location								1 🗆	Yes 2 No
e. Street and Number 14179 Carver	Manor Ci	rcle	:		10f.	Zip Code	22			10g.	Citizen of USA	of What C	ountry?	
. Marital Status  1 □ Never Married 2 □ Ma 3 ☑ Widowed 4 □ Divorce	12. Was Dec Armed F rried 1 ☐ Yes	cedent E	ver in U.S	S. 1	If Yes,	ecedent of specify Cul	Hispanic Orban, Mexica	an, Puerto	ecify Yes o Rican, etc.	or No-		lack, Whi	erican India ite, etc. hite	an,
15. Decede (Specify only high Elementary/Secondary (0-12)	nt's Education est grade completed,		' I	(G. life	ve kind of DO NO		e during mo ed)	st of work	ing		Kind of I	Business	s/Industry	
. Father's Name (First, Middle	, Last)			nurs.	ıng a	assist		er's Name	e (First, Mid		healt den Surna		are	
Hanson Leroy F									e Heb					
a. Informant's Name/Relation	ship (Type. Print)				-		et and Numb	ber or Run	ral Route N	umber, Ci	-			
connie Allison	/daughter		1-				n Cour							
a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation		n State	20b. Pl	lace of Dis	position (	Name of		- I	Date	1 200	Location	n - City or	r Town, Sta	ate
4 □ Donation 5 □ Other (			Spr	ingh rden	3	or other pla Memory		9/18		He	ebror			
Funer Service	Licensee	200	□ Ga	rden: CFSP	22 Nam HOT 501	loway Snow	ress of Facil Fune Hill	ral I	Home I , Sal:	He Profe	ebror essic cy, M			ciation
Funer: Servicional	Licensee	Caused line	□ Ga	rden: CFSP	22 Nam HOT 501	loway Snow	ress of Facil Fune Hill	ral I	Home I , Sal:	He Profe	ebror essic cy, M		Associated Appro	ciation eximate al Between t and Death
3a. Part1. Enter the disease, shock, or heart failure. Listended the Cause (Final sease or condition	or complications that only one cause on	000	□ Ga	rden: CFSP n. Do not	22 Nam HOT 501	loway Snow	ress of Facil Fune Hill	ral I	Home I , Sal:	He Profe	ebror essic cy, M		Associated Appro	oximate al Between
3a. Part1. Enter the disease, shock, or heart failure. List inmediate Cause (Final sease or condition sulting in death)  equentially list conditions, any, leading to ministrate any.	or complications that only one cause on	O (or as a	the death	rdens CFSP n. Do not uence of):	22 Nam HOT 501	loway Snow	ress of Facil Fune Hill	ral I	Home I , Sal:	He Profe	ebror essic cy, M		Associated Appro	oximate al Between
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	a	O (or as a	the death e.	rdens CFSP n. Do not uence of):	22 Nam HOT 501	loway Snow	ress of Facil Fune Hill	ral I	Home I , Sal:	He Profe	ebror essic cy, M		Associated Appro	oximate al Between
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FEMALE:  b. Was decedent pregnant in the past 12 months?  Types 2 \( \) No	b. Due to d. 23c. If yes, or 1   Live 4   Pres 9   Unkertended	o (or as a	the death e.  a consequence of pregnate 2   Fetal time of de	n. Do not pence of):	S 22 Ho T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Sand Additional Property of the Control of the Cont	ress of Face Funda Hill ving, such a	ral I	Home II, Sal:	Herofe isbur on arrest,	ebroressic cy, M	onal AD 21	Associated Approximately Onset	oximate al Between t and Death
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Apart Funers Services and Part	al Hospital:    Bar   Ba	o (or as a control of or as a co	the death e.  a consequence of pregnate 2 Fetal time of death at not result the consequence of the consequen	uence of):  Jence of):  Jence of):  Jence of):  Jence of):  Jence of):	S 22 NaT 501 S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1 S 1 S	Sand Addition of the Company of the	respondence in Part  26. Place ther: 4   N	iral I Rd. s cardiac	Home I , Sal: or respirato  23e. I  24a. 1  Y  th (Check o	Did tobace  1 Yes  Was an autopsy performed (es 22 only one)	ebroressic Cy, M	Date of de Month ontribute of a prior to death?	Associated Appropriate Appropr	Year  se of death?  14

To the Hospital or Attending Physician: he law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has then signed by the attending physician and completely filled in by the funeral director, prige 2 should be detached for use as the burial-transit

Physician /Medical Examiner

State

Registrar

DHMH 17 Rev 1/2001

829 Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Dete of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 11:50 A M 09 27 2009 Edith H. Stover /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner Homewood at Williamsport Williamsport Washington 8. Date of Birth (Month, Day, Year) 04/16/1910 5. Social Security Number 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Hours 1 □ M 2 🗓 F 99 Fayette Co, MD Director 233-30-8627 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ral", or items 23a or 28a-f shov 28a-f shov 1 ☐ Yes 2 X No Director MD Washington Williamsport 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe 21795 16505 Virginia Avenue USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: White ģ 3 X Widowed 4 ☐ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 7 is marked other than "nature traumatic event, the Wedical 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Assistant Director Presby. Childrens Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ Fred Holliday Nannie Ashley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Edward Grebenstein (Son-In-Law) 10535 Peachtree Lane, Williamsport, MD 21795 Department of Health Important: If item 27 any Injury or other troone. 20b. Place of Disposition (Name of WVU cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ■ Donation 5 □ Other (Specify) 09/29/2009 Morgantown, WV Human Gift Registry 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Rolat P.O. Box 9131, Morgantown, WV 26506 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed burlal-transit and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 attending physician for use as the burla Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given în Part I. ₹ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy perform certificate 1 ☐ Yes 1 ☐ Yes funeral director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural e Funeral Director: Af e Funeral Director: Af eletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 1 = ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated within 2. 29b. Sigral 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address TEILLE

State Registrar

6 200

		1	For State Registrar	State of Maryla	nd / Depa <i>Cer</i>	rtment of H tificate of L	lealth and M Death		glene	32933
			Decedent's Name (First, Middle, La.	st)				Date of Deat     Month	th Day Year	3. Time of Death
	Physicia			ANNETTE MERREI	J. SMTTI	1		SEP		8:55 P M
N. W.	/Medic Examin		4a. Facility Name (If not institution, giv				Location of Death		4c. County of Death	
الممير	LAGUIIII	<b>"</b>	NATIONAL NAVAL	MEDICAL CENTE	ER	BE	THESDA		MONTG	
	Funeral		5. Social Security Number 6. 5	ex 7. Age (In yrs	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	9. Birth	place (State or Foreign ntry)
	Director		570-88-8045	□ M 2 🖾 F	60 Yrs.	Working Buye		Sept. 1		chigan
	Ja	- H	Usual Residence of Decedent	100.0	city, Town or Lo	cation				10d. Inside City Limits
	arylaı <b>shov</b>		10a. State 10b. County							1 ☐ Yes 2 No
:	8a-f	Director	Maryland Kent	Cl	nestert	DWN 10f. Zip Code		- ,	10g. Citizen of What Cou	ntry?
:	ith th		10e. Street and Number	D - 1					United Stat	·
	s 23s	Funeral	7516 Quaker Neck	12. Was Decedent Ever in	110 121	21620	ispanic Origin? (Sr	necify Yes or No-		
	er de item	Š	<ul><li>11. Marital Status</li><li>1 ☐ Never Married 2 ☒ Married</li></ul>	Armed Forces? 1 ☐ Yes 2 🔀 No	0.3.	Was Decedent of H f Yes, specify Cuba	in, Mexican, Puerto	Rican, etc.)	Black, White,	
36	Irs aff	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify: W	hite
21215-0036	72 hours after death with the Maryland Inatural", or items 23a or 28a-f show dical Examinat must be notified at	ted	15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	ation	ring )	16b. Kind of Business/Ir	ndustry
	9	ple	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5+) 4		kind of work done of DO NOT use retired	during most or work	arry		
21	filed within Hygiene. other than '	Completed		4	Manag	ger			Restaurant	
nd	e file	Be (	17. Father's Name (First, Middle, Last	)					Maiden Surname)	
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan filed that had been that hydiene then 23a or 28a-f show ithen 21 is marked other than "natural" or items 23a or 28a-f show ithen traumatic event, Italian 21	၉	Ronald Flick				-	e Jacob		-
a	2 sho	111	19a. Informant's Name/Relationship	Type. Print)					er, City or Town, State, Z.	
3, 2	and lealth m 27 her tu		George D. Smith/S	pouse	7516_	Quaker No	eck Road;	Cheste	rtown, MD 2.	1620 Town, State
ore	ges 1 t of F if ite or ot		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐			sition (Name of matory or other place				
Ē	nit. Pag artmen ortant: Injury	١.	4 □ Donation 5 □ Other (Speci	fy) FT		1n Cremat	J ,	4/2009	Brentwood,	Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra		21. Signature of Funeral Service Lice	nsee		2. Name and Addre	S1	mple Tr	ibute ville, MD 20	0852
			23a. Part 1 Enter the risease, or comshoo, of heat railure. List only	plications that caused the de	ath. Do not en	ter the mode of dyi	ng, such as cardiac	or respiratory at	rrest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	METASTAT:						Onset and Death
	/Medical		resulting in death)	Due to (or as a cons						
	Examiner		Sequentially list conditions	b						
	D #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a cons	equence of):					
b	The law requires that the death certificate be executed ate has been signed by the attending physician and agge 2 should be detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	equence of):					
8760,[	be ey ician ourial			540 10 (0) 40 4 00110	04001100 0171					
87	physicate the l	dical		d						
9 x	eath certific attending p for use as	Physician/Med	IF FEMALE:	23c. If yes, outcome of preg	nancy				23d. Date of del	ivery
Вох	atter for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe	etal death 3	☐ Ectopic pregnand ☐ Other (specify) _	cy		Month	Day Year
0	the d y the	ysi	1 ☐ Yes 2 XNo 9 ☐ Unknown	9 🗆 Unknown						
σ.	w requires that the do been signed by the should be detached	F P	Part II. Other significant conditions	contributing to death but not r	esulting in the u	inderlying cause gi	en in Part I.	23e. Did t	obacco use contribute to	the cause of death?
rds	quires n sig	d by						1 🗆 '	Yes 2∭X No 3∏ Pr	obably 4 Unknown
CO	w req	Completed						24a. Was		itopsy findings available completion of cause of
Re	ician: The lav certificate has ector, page 2	m/						autoj perfo	rmed? death?	2 No
ta	un: T tificat or, pa		25. Was case referred to medical	<u> </u>			26. Place of Dea	ath (Check only o		2 110
>	Physician: r this certific ral director,	o Be	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 X Inpatient 2	☐ ER/Outpatie	ent 3 DOA Ott	201:		idence 6 ☐ Other (Spe	cify)
of	g Phy er this eral o	Ε̈́	27. Manner of Death	28a. Date of Injury (Month, Day, Year			ry at		how injury occurred	
ion	Attending r death. ector: After by the fune	atio	1 Natural 5 Pending 2 Accident investigation		,,,		]Yes 2□No			
Division of Vital Records,	or Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not determine		t home, farm, st	reet, factory, office		28f. Location ( City or To	Street and Number or Rown, State)	ural Route Number,
	Hospital o	Ce	29a. Certifier 1 😾 Certifying F	Physician: To the best of my	knowledge, dea	th occurred at the	time, date and plac	e, and due to the	cause(s) and manner a	s stated.
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate hat completely filled in by the funeral director, page	edical	(Check only 2 Medical Exa	aminer: On the basis of exam and manner stated.	ination and/or i	nvestigation, in my	opinion, death occ	urred at the time,	, date and place, and due	e to the cause(s)
	To th Withir To th comp	Me	29b. Signature and time of contifier			29c. Licen	se number		29d. Date signed (Mont	
	3		XA	3	100	RES	-000		SEP. 15	, 2009
			30. Name and address of person wh	o completed cause of death (	tem 23a) (Type	, Print)			MEDICAL CEN	ΓER
		-	JEFFREY J. LEV		USN		BETHESDA	MD 2088	89-5600	
			31. Date filed (Month, Day, Year)	→ Registrar's Si	man mike i = =					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 2009 Taylor Sept 5 obert 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) University of Maryland Medical Clinter Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/02/1933 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Days Hours Min. 1**∑** M 2□ F Maryland 219-28-1481 76 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐Yes 2 No Maryland | Anne Arundel Edgewater 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21037 United States 1600 Whiteford Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1Å∑Yes 2 □ No If Yes, Give Year or Dates: 1953-55 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerk Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thelma Louise Smith Daniel C. Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 1600 Whiteford Place, Edgewater, Maryland 21037 Brenda L. Taylor/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 09/18/09 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Fu Service Lice see los 2973 Solomons Island Road, Edgewater, MD 21037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or reart failure. List only one cause on each line. Approximate Interval Between Onset and Death Due \* (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify)

Physician /Medical Examiner

be executed

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

ð

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, its Medical Examinar must be notified at

within 72 hours after death with

12 should be filed within in and Mental Hygiene.
7 is marked other than "r

permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur

Maryland 21215-0036

altimore,

Examine burial-transi and led by the attending physician detached for use as the burial Physician/Medical e Hospital or Attending Physician: The law requires that the death certificate 2 thours after death.

2 thours after death.

2 thours after do... After this certificate has been signed by the attending physis leiely filled in by the funeral director, page 2 should be detached for use as the t 2 Completed Be Medical Certification: To

Imme ause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Usease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗙 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

4+1

within 2

State Registrar

Medical of Manyland University

AU4176435B19639

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

22 South Greene St Baltimore MD 21201

#### 09-07513 Andrew Taylor

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death -1. Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 26, 2009 0756 hrs Andrew B. Taylor Medical Examiner 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Frederick Mversville 3924 Bretchen Church Road 9. Birthplace (State or 8. Date of Birth(MM/DD/YYYY) If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Country) PA Hours Min. Months 01-01-1980 Director 29 Yrs. 1 XM 2 171-70-4378 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 X Yes 2 No Biglerville PA Adams Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 17307 50 Ditzler Avenue USA with the 14. Race - American Indian, Black, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 X Never Married 2 Married 1 X Yes Specify: White Yes 2X No specify: Widowed Divorced If Yes, Give Yeer hours after ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 l nent of Health and Mental Hygiene. Baltimore, MD 21215-0036 5+ 12 Youth Counselor Youth Center 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Jeanette R. Alexander Edwin B. Taylor Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 is n 50 Ditzler Avenue Biglerville, PA 17307 Ryan E. Taylor/brother 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Fairview Cemetery Arendtsville, PA Department o 09-30-2009 Other Specify: Donation 5 22. Name and Address of Facility 12525 Bradbury Avenue Signature of Funeral Service Licenses J. L. Davis Funeral HomeSmithsburg. MD 21783 CULLY Approximate Interval ter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Partil Enter he disease, or complications failule. List only one cause on each line. Physician Between Onset and Death Medical a. Contact Gunshot Wound of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last executed Physician/Medical AMENDED UNPENDED signed by the attending physician be detached for use as the burial Division of Vital Records, P.O. Box 68760, the Hospital or Attending Physician: The law requires that the death certificate be thin 24 hours after death. 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 Unknown Completed 24h. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy has performed? Yes Yes 2 V No 2 No After this certificate 26 Place of Death (Check only one) 25 Was case referred to medical Be Other<sub>4</sub> examiner? Hospital: DOA Nursing Home 5 Residence 6 V Other: Scene ER/Outpatient 3 Inpatient 2 1 Yes 28a. Date of Injury (Month, Day, Year) FOUND: 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death Subject shot self Certification: e Hospu...
n 24 hours after death.
the Funeral Director: A FOUND: 1 Yes 2 V No Natural 5 Pending Sep 26, 2009 0750 hrs Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 🗸 Suicide 6 Could not be or Town, State) 3924 Bretchen Church Road, Myersville, MD (Specify) Parking Lot Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1 Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 27, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Patricía Aronica-Pollak MD. Assistant Medical Examiner

State Registrar

ORIGINAL

32. Registrar's Sanature

31. Date filed (Month, Day, Year)

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ician	1. Decedent's Name (First, Middle, La							N	ate of Death Ionth	Day	Year	3. Time of Death	
dical	George B. Tru  4a. Facility Name (If not institution, giv				4h Cibu	Town or	Location of F		pt. 16	4c. County	of Death	0.75A	
niner	9288 Hickory Mill				4b. City, Town, or Location of Death Salisbury			Jean			omico		
al or	5. Social Security Number 6. 5		e (In yrs. las 94	st birthday) Yrs.	If Under Months		If Under 24	Hrs. 8. D	ate of Birth Month, Day, Y 20/191	(ear)	Cour	lace (State or Foreign try) yland	
Į.	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Loca							1	0d. Inside City Limits	
ecto	DE Susse	2X		Delman		Code			10g. Citizen of What Country?				
	402 East Jewel	Street			10f. Zip Code 19940					U.S.A.			
once.  To Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married	Ever in U.S. No			dent of H	ispanic Origir in, Mexican, F	n? (Specify ) Puerto Ricar	Yes or No- n, etc.)	Blac	ce - Americ ck, White, o	etc.		
d by	3 ☑ Widowed 4 □ Divorced						1 40						
Completed	15. Decedent's Education (Specify only highest grades) Elementary/Secondary (0-12)	16a. Decede (Give k life. De Mecha	ind of wor O NOT us	rk done d	during most of	f working	16	8b. Kind of Bi		dustry			
To Be C	17. Father's Name (First, Middle, Last Larry W. Tru								st, Middle, Ma Foskey		ne)		
-	19a. Informant's Name/Relationship				,	•	and Number					Code)	
	Loveyann T. Call	Loway (Dau					g Lane		vie, MI	D 207		um Stata	
	20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐  4 ☐ Donation 5 ☐ Other (Special		cer	-	n's	ther plac Ceme	tery 0			De1mar	,	wii, State	
ouce.	21. Signature of Funeral Service Lice		u	22.   S   1	hort 3 E.	Fun Gro	ss of Facility eral H ve Str	ome eet, 1	Delmar	, DE	19940	)	
in al	23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	plications that caused one cause on each li a	ne.	EME	r the mod	le of dyir	ng, such as ca	irdiac or res	piratory arres	t,		Approximate Interval Between Onset and Death	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events  b. Due to (or as a consequence of):												
Medical Examir													
9	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1												
ed by Ph	Part II. Other significant conditions	contributing to death b	out not result	ting in the und	derlying c	ause giv	en in Part I.			cco use con		he cause of death?	
Completed								_	24a. Was an autopsy performe 1 □Yes 4	ed2	Were autoprior to codeath?	psy findings available impletion of cause of 212 No	
Be (	25. Was case referred to medical examiner?								eck only one)				
tion: To Be C	1 Yes 2 No  27. Mann of Death Natural 5 Pending	Hospital: 1 Inpati 28a. Date of Inju (Month, Da	ıry 2	R/Outpatient 28b. Time of Injury	2	28c. Injur Wor	y at k?	28d.	5 Resident			MASSIS JEV LIV	
Medical Certification: To Be Completed by Physician/	2 Accident Investigatio 3 Suicide 6 Could not be determined	e 28e. Place of Inj	ury - At hon c. (Specify)	ne, farm, stre	M et, factory		Yes 2□No	28f. L	ocation (Stre City or Town,		ber or Run	al Route Number,	
Medical C		hysician: To the best miner: On the basis of and manner st	of examinati										
<u>a</u>	29b. Signature and title of certifier			-	20	Licens	e number		20	d. Date signe	ed (Month	Day Voorl	

To the Hospital o within 24 hours aft To the Funeral Di

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State Registrar of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 22, 2009 Year 8:03 A **Physician** Richard Verzwyve1t Michael /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Suburban Hospital Bethesda 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Oct. 12, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Louisiana Months Days Min XXXM 2□ F 434-74-8999 60 Director Usual Residence of Decedent 10d. Inside City Limits 10b County 10c. City, Town or Location 10a State show d other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be rediffed at 1 □Yes 2XTXNo Director Maryland Prince George's Oxon Hill 10g. Citizen of What Country? 10e. Street and Number USA 20745 6277 Oxon Hill Road # 202 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 72 hours after 1<del>€</del> Yes 2 □ No If Yes, Give 1970–90 Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 XNo Specify. Specify White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired)

Staff Sgt. College (1-4or 5+) U.S. Air Force Elementary/Secondary (0-12) 12 12 should be filed whand hand Mental Hygier is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Verzwyvelt Fabian Louis Eva Agnes Mathews ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health ar 6277 Oxon Hill Road #202 Oxon Hill, Maryland Mary T. Verzwyvelt / Wife mit. Pages 1 and partment of Health cortant: If item 27 injury or other tr altimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XXCremation 3 ☐ Removal from State 9/23/2009 Department Important: If any injury or once. Edgewater, Maryland Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home P.A. uneral pervice Licensee 21. Signature 6160 Oxon Hill Road Oxon Hill, Maryland 23a. Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS Physician /Medical Due to (or as a consequence of): Examiner MRSA ENDOCARDITIS Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit SEPTIC EMBOLI Due to (or as a consequence of): MALNUTRITION Physician/Medical Box IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director. Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 npatient 2 ER/Outpatient 3 DOA Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? ty Y Natura 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident or Attendate after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ang SWARSHAN 9/22/09 1165312 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sudarshan Siva MD 8600 Old Georgetown Rd. Bethesda, Maryland 31. Date filed (Month, Day, Year, 32. Registrar's Si SEP 2 3 2009 Registrar

DHMH 17 Rev 1/200

RICHARZD

FRZWYZFU

Sept 2009 Georgie Marie Wingrove **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Solomons Solomons Nursing Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Sept 9 1935 5. Social Security Number 7. Age (In vrs. last birthday Funeral Days Hours 74 Director 218-30-8346 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a State 28a-f show Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any niqury or other traumatic event, the Medical Evantinar is ust be reaffed at once. Prince Frederick Calvert Maryland **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20678 3822 Cassell Blvd. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □Yes 2 □ If Yes, Give X Year or Dates: 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) office Worker US Government 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James Alexander Wilkinson Mary Magdelin ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3822 Cassell Blvd. Prince Frederick, MD 20678 Gary Steven Strine - son 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept 23<sup>D2</sup>2009 Chesapeake Highlands Memorial Gardens 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Port Republic Maryland 4 ☐Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home PA 21. Signature of Funeral Service Licensee 4405 Broomes Is. Rd. Port Republic MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stage **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner mokins Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months?
1 ☐ Yes 2 No 5 ☐ Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 2 7 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 | Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident

6 ☐ Could not be

determined

Blatton

3 Suicide

29a, Certifier

Medical

4 Homicide

(Check only one)

Swyneth

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No

3. Time of Death

345 P

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 ☐ Yes 2 🗷 No

Year

Maryland

white

2. Date of Death

Division of Vital Records,

1 - For State Registrat

1. Decedent's Name (First, Middle, Last)

drw) State Registrar 🕰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

32. Registra s Signature

30 Name and address of person who completed cause of death (Item 23a) (Type, Print

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 12:10 am 22 2009 September Tania Ena Eileen Williams /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Shady Grove Adventist Hospital Rockville. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign
Country) **Funeral** Min. Months Days Hours 1 □ M 2 🗷 F United Kingdom October 9, Director 225-51-6862 51 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐Yes 2 X No Directo Gaithersburg Maryland Montgomery 10f. Zip Code 10g Citizen of What Country? 10e. Street and Number 23a or death with 200 Bookham Lane 20877 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or item 1 Never Married 2 Married 1 ☐ Yes 2 🖺 No Specify. Yes. Give þ Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: **Black** Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Information Technology 4 Consultant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ٥ Coleridge H. H. Coker, Sr. June Elizabeth Eileen Maxwell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Coleridge H. H. Coker, Jr. - Brother 200 Bookham Lane, Gaithersburg, Maryland 20877 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If it any Injury or conce. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 10/10/2009 Silver Spring, Maryland 4 Donation 5 Other (Specify) permit. Signature of Funeral Service Licensee Mo # (070 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or bear ratiure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Physician NO Can resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 1 ☐ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 40 1 ☐Yes 2 ☐No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 110 Certification: To 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0064502 September 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

SEP

23

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Brian Carpenter, M.D., 9901 Medical Center Drive, Rockville, Maryland 20850

32 Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			- negistral	rtment of Health and IV tificate of Death	Reg	. No. 110 32011
П	Physici	an	1. Decedent's Name (First, Middle, Last)  Dorothy B. West		2. Date of Death Month Septembe	Day Year 20, 2009 10:30 %
alan,	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Death
and the same			Manor Care-Potomac  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Potomac  If Under 1 Year   If Under 24 Hrs.	8 Date of Birth	Montgomery  9 Birthplace (State or Foreign
	Funeral Director		213-38-3228 1 M 2 F 99 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, ) Feb. 21,	9. Birthplace (State or Foreign Country) Ohio
	yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loc	ation		10d. Inside City Limits
	8a-f s	Director	Maryland Montgomery Chevy Ch			1 ☐ Yes 2 ☐ No
	3a or 2	al Dire	10e. Street and Number 8100 Connecticut Avenue, Apt. 1114	10f. Zip Code <b>20</b> 8	,	g. Citizen of What Country? USA
21215-0036	72 hours after death with the Maryland "natural", or Items 23a or 28a-f show official Examinar must be motified at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2 ♣ No	As Decedent of Hispanic Origin? (Sp Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
15-0	be filed within 72 ho ital Hygiene. d other than "natui event, ire Medicia	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give kilds of the completed)	ent's Usual Occupation ind of work done during most of worki O NOT use retired)	ing   16	Sb. Kind of Business/Industry
212	I within giene.	ошо	Elementary/Secondary (0-12)   College (1-4or 5+)	entary School Teac		Education
pu	be filed intal Hygid dother event, II	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name		aiden Surname)
Maryland	Mer Mer arke	၉	Andrew Elza Barton  19a. Informant's Name/Relationship (Type. Print)  19b. Mailin	Mabel Sk		City or Town State Zin Code)
	12 17 17 17			Ridge Drive, McI	ean, Vir	ginia 22101
Baltimore,	Pages nent of ant: If It ary or c		TEDONALON SECURITY	tan Crematory	pt. 22	oc. Location - City or Town, State  Alexandria, Virginia
Balt	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service Licensee	Name and Address of Facility Trancis J. Collins OO University Bly	Funeral	Home Inc. ilver Spring,MD 20901
Ī			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arres	st, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Myocardial Infarct	ion		1 day
1	Examiner		Due to (or as a consequence of):			
4	ad sit	iner	Sequentially list conditions, if any, leading to immediate cause (Disease or injury			
	execut n and al-tran	Examiner	that initiated events resulting in death) Last C			
68760,	ificate be executad g physician and is the burial-transit	edical	d	····		
-		/Med	IF FEMALE: 23c. If yes, outcome of pregnancy		7	23d. Date of delivery
.O. Box	requires that the death cer been signed by the attendin nould be detached for use	Physician/M	in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnancy Other (specify)		Month Day Year
s, P.	res that signed b be deta	by Pł	Part II. Other significant conditions contributing to death but not resulting in the un	derlying cause given in Part I.		acco use contribute to the cause of death?
ord	w requires been si should b	ted	Polymyalgia Rheumatica			2 No 3 Probably 4 XUnknown
of Vital Records,	The law ate has t	Completed			24a. Was an autopsy perform 1 🗆 Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  ☑ No 1 ☐ Yes 2 ☐ No
Vita	Physician: The this cartificate ral diractor, pag	æ	25. Was case referred to medical examiner?  Hospital: Ho	Othor	h (Check only one	
of	ding Phys h. After this funeral di	n: To	27. Manner of Death 28a. Date of Injury 28b. Time of	28c. Injury at Work?	28d. Describe hov	nce 6 Other (Specify) v injury occurred
sion	e at a	atio	1 X Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	M 1 ☐ Yes 2 ☐ No		
Division	after deatl Director: d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street building, etc. (Specify)	eet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by th	edical C	29a. Certifier  (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, death one)  1 ☑ Certifying Physician: To the best of my knowledge, death one of the basis of examination and/or improve and manner stated.	n occurred at the time, date and place vestigation, in my opinion, death occur	and due to the ca red at the time, da	use(s) and manner as stated. te and place, and due to the cause(s)
	To the within To the Comp	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Month, Day, Year)
	10		, , , , , ,	D00545	66	1/21/09
		ł		orgia Avenue, #1-	-17, Silv	er Spring, MD 20902
	Sta Registr		31. Date filed (Month, Day, Year) 2. Begistrar's Signature A. Jan	W.		

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 12:10 am September 21, 2009 Wasserman Beatrice 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number 7. Age (In vrs. last birthday) Days Months 1 □ M 2 🔀 F Yrs. New York 95 July 23, 1914 056-09-9532 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 □Yes 2 No Rockville Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20852 U.S.A. 6111 Montrose Road, #216 Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 No If Yes, Give Year or Dates: 1 □Yes 2 No Specify. Specify: 3 X Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Broker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Annie Greenfield Solomon Feller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2311 Connecticut Avenue, NW, Washington, DC 20008 Roberta Wasserman - Daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 🔀 Burial 2 Cremation 3 Removal from State 09/23/2009 Farmingdale, New York New Montefiore Cemetery 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility **Hines-Rianldi Funeral Home, Inc.** 21. Signatur of Funeral Service Licenses 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 25 days Hip Fracture Complication moone Due to (or as a consequence of): Due to (or as a consequence Due to (or as a consequence of): yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death
☐ Pregnant at time of death 23d. Date of delivery 3 🗌 Ectopic pregnancy Month Day Year 5 Other (specify)

**Physician** /Medical Examiner

certificate be executed

The law requires that the death

Hospital or Attending Physiclan: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director, p.

24 hours a

within 2

P.O. Box 68760,

Division of Vital Records,

**Physician** 

/Medical

Examiner

10a. State

**Funeral** 

**Director** 

28a-f show

Director

Funeral

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Completed

Be

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d other than "natural", or items 23a or 28a-f sho event, the Wedical Evasitant must be modified at

72 hours after

2 should be filed who and Mental Hygien is marked other the

permit. Pages 1 and 2 st Department of Health and Important: If Item 27 Is n any injury or other traum

Baltimore, Maryland 21215-0036

sician and burial-trans attending physician for use as the buria signed by the a d be detached f icate has been si, page 2 should b certificate

Examine Physician/Medical <u></u> Completed 25. Was case referred to medical examiner? Be Certification: To 29a, Certifier

Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? ☐Yes 2 X No q □ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 X Yes 2 □ No

4 Homicide

29b. Signature

g \ Unknown

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 K Unknown

24a. Was an autopsy performed? 1 □ Yes 2 🛣 No 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 ☐ Yes

28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 5 Pending investigation 08/25/2009 2 😾 Accident 6 ☐ Could not be 3 Suicide determined

28c. Injury at Work? Injury EM 1 ☐ Yes 2 K No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred Fa11

28f. Location (Street and Number or Rural Route Number, R City or Town, State (1) 1775 100 K

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number

dress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 30

31. Date filed (Month, Day, Year) State 23

. Registrar's Signature

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Group Home

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8:00 2009 September 19, Henry David Wright, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 15570 Peachwalker Drive Rowie. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours 1⊠M 2□ F Yrs. January 20, 1955 Washington, DC 219-64-1467 54 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Prince George's Bowie the ! 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number filed within 72 hours after death with USA 20716 15570 Peachwalker Drive Funeral Was Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1974–1981 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify. ģ 3 ☐ Widowed 4 ☐ Divorced Be Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) withir, ...
127 is marked other than "r traumatic even" Elementary/Secondary (0-12) College (1-4or 5+) US Navy Military Police 12 18. Mother's Name (First, Middle, Maiden Surmame) 17. Father's Name (First, Middle, Last) 2 should be fi Henry David Wright, Sr. Juanita Joyce Spears ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 Henry D. Wright, Sr. / Father 6030 67th Place, Riverdale, MD 20737 Department of Health Important; If item 27 any Injury or other tr 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Brentwood, Maryland 9/23/2009 Fort Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, PA slance Jase Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician are disease or condition resulting in death) /Medical nseque ce of) Due to (or > Examiner AU if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed burial-trar Due to (or as a consequence of): physician a Box 68760, Physician/Medical law requires that the death certificate attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) signed by the a P.0. 9 H Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy performed 1 ☐Yes 2 ☐ No certificate 1 □Yes 2 □No Division of Vital or Attending Physician: 26. Place of Death (Check only one) director. 25. Was case referred to medical Be examiner: 1☐ res 2☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury
(Month, Day, Year)

28b. Time of 126c. Injury
(Month, Day, Year)

28c. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) After thi 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident within 24 hours after death

To the Funeral Director:

completely filled in by the i 6 ☐ Could not be 3 Suicide (Street and Number or Rural Route Number, 28f. Location (Str. City or Town 4 ☐ Homicide out doors

To the Hospital 10t

State Registrar

Medical

31. Date filed (Month. Day.

29b. Signature and title of certifier

29a. Certifier

(Check only one)

50 32. Registrar's Sign

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Wilbert Williams 5:31 РМ 2009 September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Pringe George's Hospital Prince George's Cheverly Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1 X M 2 D F Yrs. 213-46-8422 82 Director December 10,1926 North Carolina Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28e-f show ed other then "natural", or Items 23a or 28e-f show event, the Medical Examinar must be multipled at 1 X Yes 2 □ No Maryland| Prince George's Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5805 42nd Street, #504 20781 USA Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mentel Hygiene. nent of Heatth and Mentel Hygiene. ant: If Item 27 is merked other then "natural", or Items 23 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2 ဩNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. δ Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Safeway 12 Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charlie Williams Carrie Powell ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Carol Williams / Attorney 3 Bethesda Metro Ctr., Bethesda, MD 20814 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot
once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia Metropolitan Crematory 9/22/2009 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Gasch's Funeral Home, P.A. Hyattsville, MD 20781 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsis 4 Weeks /Medical Due to (or as a consequence of): Examiner Ischemic Colon 4 Weeks Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of); law requires that the death certificate be executed Exami sician and burlal-tran Due to (or as a consequence of): Box 68760, ettending physician for use as the burla Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 ☐ Pregnant at time of death 5 Other (specify) P.O. signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Renal Failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ₺ Unknown Completed Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? certificate Respiratory Failure 1 ☐ Yes 2 ☐ No Division of Vital 1 ☐ Yes 2 No Hospital or Attending Physician: this certific al director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ After this funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending n 24 hours after death.

e Funerel Director: Aftetely filled in by the fur investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Revathy Murthy, 6130 Landover Road, Cheverly, MD 20785 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State SEP 2 3 2009 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** SEPTEMBER<sup>ay</sup>18 2009 JR. WHITE 12:18P M HENRY JOHN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY TAKOMA PARK WASHINGTON ADVENTIST HOSPITAL Birthplace (State or Foreign Country) **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1 → M 2 □ F Days Hours Yrs. Director 222-34-8386 21 1950 GEORGIA Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits show is marked other than "natural", or Items 23a or 28a-f shot aumatic event, the Medical Examinar must be mylified at Director 1 X Yes 2 □ No MD PRINCE GEORGE'S MT. RAINIER 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 20712 by Funeral 4205 KAYWOOD DRIVE 1A 12. Was Decedent Ever in U.S.
Armed Forces?
1 PYes 2 No ARMY Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 □Yes 2 No Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 2 should be filed within and Mental Hygiene. PRIVATE RADIO permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked othe any Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROSIE PRINCE JOHN HENRY WHITE SR. 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11807 HEARTWOOD DRIVE BELTSVILLE, MARYLAND 20705 TERRY LEE WHITE SR./BROTHER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation \_\_5 ☐ Other (Specify) MD VETERANS CEMETERY 9/25/09 CHELTENHAM, MARYLAND Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to inmodifie cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine quence of) The law requires that the death certificate be executed attending physician and for use as the burial-tran Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) P.0. s been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate ha autopsy performed? Division of Vital 1 ☐ Yes 2 ☐ No 2√□ No the Hospital or Attending Physician: director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manne et eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation n 24 hours after death.

le Funeral Director: Af 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 ho

To the Fune

completely f 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person o completed cause of death (Item 23a) (Type, Date filed (Month, Day, Year) 32. Registrar's Signature State SEP 2 3 2009 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 7:26 P<sup>M</sup> SEPT MARGARET Μ. WASKIEWICZ 18 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** 707 HURRICANE ROAD WORCESTER OCEAN CITY If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛛 F Months Days Hours Min. 68 15, 274-34-4259 DEC. Director 1940 OHIO Usual Residence of Decedent the Maryland 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Medical Examinant to undifferent any injury or other traumatic event, its Medical Examinant to undifferent applica. 10a State 10b. County 10c, City, Town or Location Director 1 X Yes 2 □ No WORCESTER MARYLAND OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 707 HURRICANE ROAD 21842 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 █No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No If Yes, Give Year or Dates Specify. Specify: WHITE þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CO-OWNER MANUFACTURING 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN HAYES ပ RITA GLEN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ANTHONY S. WASKIEWICZ/HUSBAND 707 HURRICANE ROAD, OCEAN CITY, MD 21842 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State GATE OF HEAVEN CEM. 4 ☐ Donation 5 ☐ Other (Specify) 9/23/09 DAGSBORO, DELAWARE 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause of each line. eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final 6 tasta 170 Jan Small Ca **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Examil Due to (or as a consequence of): P.O. Box 68760 attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has certificate 1 □Yes 2 🖾 🚾 Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one, examiner' Other: 4 \(\sum \) Nursing Home 1 Yes 2 No 5. Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 5 Pending investigation n 24 hours a er death.

ne Funeral Director & pietely filled in by the fi death. 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only and manner stated To the I within 2. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar Name

address o

Date filed (Month)

Year 2

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Jank

St. Salisburum

Tison who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Ivial yil		ertificate of L			Reg. No.	0 9 9	32045
П	Physicia		1. Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic		Donald E. Wa	1ter				Septen	nber 17	, 2009	8:58 A M
1	Examin	er	4a. Facility Name (If not institution, give str				Location of Death			ty of Death	
, state			9820 Sharptown R  5. Social Security Number 6. Sex		rs. last birthda		lela Spri If Under 24 Hrs.			omico	
	Funeral Director			M 2DE	0 Yrs.	Months Days	Hours Min.	Nov. 26	y, Year)		place (State or Foreign ntry) yland
	P.		Usual Residence of Decedent					11.0 7 7 - 0	, -,		
	show	<u>_</u>	10a. State 10b. County	10c.	City, Town or	Location				1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	he M.	Director	MD Wicomico		Marde	la Springs			10g. Citizen o	Mhat Cau	
	with t		10e. Street and Number	1		10f. Zip Code 2183	7		U.S.		nu y r
	ns 23	Funeral	9820 Sharptown R	. Was Decedent Ever in	n U.S. 13			ecify Yes or No-		A • ace - Ameri	can Indian.
0	r iter	표	1 ☐ Never Married 2 ☑ Married	Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give		B. Was Decedent of H If Yes, specify Cuba		Rican, etc.)	ВІ	ack, White,	
ğ	ral", o	l by	3 Widowed 4 Divorced	If Yes, Give Year or Dates: <b>Vie</b>	tnam	1 ☐ Yes 2 🛣 No	Specify:		Spec	ify: w	nite
21215-0036	filed within 72 hours after death with the Maryland Hygiene. thet than "natural", or items 23a or 28a-f show ant, the Medical Examiner ment be notified at	Completed	15. Decedent's Educa (Specify only highest grade of	tion completed)	16a. Dec	cedent's Usual Occup oe kind of work done o . DO NOT use retired	ation during most of work	ring	16b. Kind of	Business/In	dustry
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2	filed v Hygic ther t	ပိ	17. Father's Name (First, Middle, Last)		UWI	ner/Operat	18. Mother's Nam				ce ilucking
$\subseteq$	be od o	To Be	William Walter				Ruth (	·			
ar y	2 should and Men is marke aumatic	ř	19a. Informant's Name/Relationship (Type	e. Print)	19b. Ma	iling Address (Street	and Number or Rui	ral Route Numbe	er, City or Tow	n, State, Zij	o Code)
	is 1 and 2 should of Health and Mei item 27 is marke other traumatic		Diane K. Walter	(Wife)	9820	) Sharptow	n Road	Mardela	Sprin	gs, l	MD 21837
e.			20a. Method of Disposition	20	b. Place of Dis	position (Name of ematory or other plac	re)	Date	20c. Location	n - City or To	own, State
Ē	Pages ment of ant: If its ury or o		1 ☐ Burial 2 XCremation 3 ☐ Rei 4 ☐ Donation 5 ☐ Other (Specify)	novai from State		y of Delma	i	2-2009	Delmar	, Del	aware
Baltimore,	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licensee	t-downe	u	22. Name and Addres Short Fune 13 East Gi	eral Ĥome		lmar, I	E 19	940
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X	/Medical		resulting in death)	Due to (or as a con		d					
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89	tificate ng phy as the	edic	u.						1		
ROX	death certificate be executed e attending physician and d for use as the burial-transit	Physician/Medical	23b. was decedent pregnant	c. If yes, outcome of pre		□ Estania pregnanc			23d. E	ate of deliv	very
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0	y Phy er this eral d	n: To	27. May er of Feath	28a. Date of Injury (Month, Day, Yea		of 28c. Injur	y at	ome 5 Residence 1			rry)
0	nding ath. r: Aft e fun	atio	Natural 5 Pending investigation	(Month, Day, Yea	r) Injur		Yes 2□No				
DIVISION	r Atte ter de irecto i by th	ertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - A building, etc. (Sp	At home, farm, pecify)	street, factory, office		28f. Location (S City or Tov	Street and Nur vn, State)	n <i>ber</i> or Rui	al Route Number,
ם	oital o urs af ral D	O		<u> </u>							
	To the Hospital or Attending Physician: The law within 24 Hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 or	Medical	29a. Certifier (Check only one) Certifying Physic (Check only one)	cian: To the best of my er: On the basis of exar and manner stated.	nination and/or	investigation, in my o	me, date and place ppinion, death occu	, and due to the rred at the time,	date and place	manner as e, and due t	stated. to the cause(s)
	To th withir To th comp	Me	29b. Signature and title of gertifier	1111	)	29c. Licens	e number		29d. Date sign	ned (Month	Day, Year)
	^		ADE 25	III,	M	De	2627		7-1	17-	09
	5 mg		30. Name and address of person who com	pleted cause of death (	(Item 23a) (Typ	e, Print)	0 0		20	( )	N 21601
	l v v		21 Date filed (Martin Day Your)	32. Registrar's Si	ignature /	Haspile	NO R	x 173.	5 201	Eh, 1	no 0/80/
	Sta Registr		31. Date filed (Month, Day, Year)  SFP 2 1 200	9 Drue	A. A	parker					

State Registrar 31. Date filed (Month

Baltimin

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ta

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Haller Charles Zeller Lynn Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Washington Washington County Hospital Hagerstown Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Date of Bill. (Month, Day Y an. 28 1 🗆 M 2 🗶 F Months Days Hours Director 215-20-8959 86 Maryland 1923 Jan. Usual Residence of Decedent show 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City, Town or Location within 72 hours after death with the Maryland 10d, Inside City Limits Directo Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1 Stouffer Avenue 21740 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 0 Armed Forces Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married þ 2 A No Yes Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give 3 X Widowed 4 Divorced Specify: Completed White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72. th and Mental Hygiene. The marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Clerk County Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Victor Haller Inez Charles 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other fram Phyllis Grove / Niece Stouffer Avenue 21740 Hagerstown, Maryland Baltimore, 20a. Method of Disposition
1 💆 Burial 2 🗆 Cremation 3 🗆 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 4 Donation 5 Other (Specify) Rest Haven Cemetery : 09/28/2009 Hagerstown, Maryland . Signature of Fund Service Licensee del Bast Stauffer Funeral Home, P.A. 760<u>6</u> 01d <u>National Pike</u> Boonsboro, MD 21713 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one disease. ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, is on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Du to (or as a consequence of): strointestina disease or condition hou Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to jor as a consequence of sician and burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_ in the past 12 months? Day Pregnant at time of death 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed Hypertensive Heart Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Dementia Yes 2 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ည 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

D47451

Cypithia Kuttner Sands, mo

SFP 25 2000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) wrsing Home, Cynthia Kuttner Sands, mp Homewood Wursing Home,

september 23,2009

Maryland 2179S

16505 Virginia Ruenue

			State of Maryland / Depart  1 - State Registrar Certif	ment of Health Ficate of Deat		ntal Hygien Reg. N	911119	32049
			Decedent's Name (First, Middle, Last)			Date of Death		3. Time of Death
	Physici /Medio		Sidney Zirin				16, 2009	1:10 P M
	Examir			. City, Town, or Locatio	n of Death	4	c. County of Death	
640			1	Bethesda	an Od Haa Ta		Montgomer	
L	Funeral Director		133-14-3757	Under 1 Year If Undonths Days Hours	er 24 Hrs. 8. s Min. Ma	Date of Birth (Month, Day, Yea 19, 19,	9. Birthpl Count New Y	
	pug *		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location	on.			10	d. Inside City Limits
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	the P	Director	Maryland Montgomery Rockville  10e. Street and Number	0f, Zip Code		10g. C	Citizen of What Count	rv?
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	death	Funeral		Decedent of Hispanic ( s, specify Cuban, Mexic	Origin? (Specify		14. Race - America	an Indian,
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Medical Evantian must be motified at once.	è	1 ☐ Never Married 2 ☐ Married   1 ☐ Yes 2 🔀 No	s, specity Cuban, Mexic Yes 2⊠No <i>Speci</i>		in, etc.)	Black, White, e	
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Ë	Page nent c int: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)  Ft. Lincolr		9/23/	09 Bre	ntwood, Ma	arvland
Baltimore,	permit. Departr Importa any inju		21. Signature of Fungral Service Licensee 22. Na	ame and Address of Fac	cility Simpl	e Tribut	е	
			23a Part 1 Enterthe disease or complications that caused the death. Do not enter the	0 Rockville				
	Physician		shock, of heart failure. List only one cause on each line.  Immediate Cause (Fina					Approximate Interval Between Onset and Death
	/Medical		disease or condition resulting in death)  a. Acute myccardial inf  Due to (or as a consequence of):	arction				-
	Examiner							
	73 ~	ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	acuter nd transi	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.					
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9 x	ding I		IF FEMALE: 23c. If yes, outcome of pregnancy					
P.O. Box	leath certific attending p	Physician/M	in the past 12 months?	topic pregnancy her (specify)			23d. Date of deliver Month	ry Day Year
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т, П	s that ned b e deta	by Pi	Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Par	t I.	23e. Did tobacco	use contribute to the	e cause of death?
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œ —	The I	Ë				autopsy performed? 1 □ Yes 2 ☑ N	death?	npletion of cause of
ita	sician: The certificate h rector, page	Bec	25. Was case referred to medical examiner?	26. Pla	ce of Death (C		10103	- L140
<u>&gt;</u>	hysic this o		1 ☐ Yes 2 ☑ No Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3	DOA Other: 4 🗆	Nursing Home	5 ☐ Residence	6 ☐Other (Specify	)
ion	nding Path. r: After t e funera	ation:	27. Manner of Death  1 X Natural 5 □ Pending  2 □ Accident investigation  28a. Date of Injury (Month, Day, Year)  Injury  28b. Time of Injury  Injury	28c. Injury at Work? M 1 □ Yes 2 [		Describe how inj	ury occurred	
Division of Vital Records,	al or Atte s after des l Directo d in by th	Certification: To	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, building, etc. (Specify)	factory, office	28f.	Location (Street a City or Town, Sta	and Number or Rural ite)	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical C	29a. Certifier  (Check only one)  1 ☑ Certifying Physician: To the best of my knowledge, death occar and manner stated.	curred at the time, date igation, in my opinion, d	and place, and leath occurred a	due to the cause at the time, date a	(s) and manner as st and place, and due to	ated. the cause(s)
	To the To the Comp	M	29b. Signature and title of certifier	29c. License number	r	29d. D	Date signed (Month, L	Jay, Year)
	3		<b>\</b>	D66066		9/	16/09	
	~		30. Name and address of person who completed cause of death (Item 23a) (Type, Print Andrew Wong, M.D. 8600 Old Georgetow	,	thesda.	MD 2081	4	
	Sta	te						
	Registr	ar	31. Date filed (Month, Day, Year) SEP 2 3 2009  32 Registrar's Signature.					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle. Month ( **Physician** 210 m /Medical Death Examiner 70 If Under 24 Hrs. 8. Date of Birth (Month, Day. 7. Age (m yrs. last birthday) If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Months 1 □ M Director Usual Residence of Deceder the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County item 27 is marked other than "natural", or iteme 23a or 28a-f show other treumatic event. It a Medical Examinar must be notified at 1 Yes 2 No Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21208 LSA Funeral death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 (1) Yes 2 (1) No. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specity: Specify: β 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 19513tax 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last To Be rbert 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) . Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) Country MD 21208 Department of Health a Important: if item 27 is any Injury or other tre once. ardling - neice barbara 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State Kidge 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. W 2120 Balto Immediate Cause (Final **Physician** leze disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner ending physician and use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) ed by the attending physician detached for use as the burial P.O. Box 68760, Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 menths? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed b 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 2 No 3 Probably 4 Unknown should s certificate has been lirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 Yes After this certifical funeral director, p 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Certification; To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Hodrsing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation within 24 hours after deal To the Funeral Director. 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 | Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

The Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and the of certifier 29c. License number 09/09/2009 125112 30. Name and address of person who complete cause of death (Item 23a) (Type, Print)
TAHOORA KAWAJA 20, Cross roads nive Scuttlo1 Owings Hell

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State

Registrar

TAHOORA 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records,

**Funeral** 

Director

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items 23a

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permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natur any injury or other traumatic event, It a Medical sone.

**Physician** 

/Medical

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Andresini, Joseph

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

W.D

29c. License number

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

69540

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

walkam woods Rd Suite 205 Parkville MD 21234 SHAH. JIGAR 8813

31. Date filed (Month, Day, Year)

32. Registrar s Signature

		•	1 - State Registrar	State of Marylan	-		nt of Healt te of Dea			giene, Reg. No.	2009	32052
			Decedent's Name (First, Middle, Last,						2. Date of Dea	ath Day	Year	3. Time of Death
	Physici		Manuel B	F F F F F F F F F F F F F F F F F F F					Sent	30	2007	6:10 aM
\ \ !	/Medio Examin		4a. Facility Name (If not institution, give			4b. City	, Town, or Locat	tion of Death		4c.	County of Death	
			North wast Has	A. to Centre	_		aulls L				CITIA	
	Funeral		5. Social Security Number 6. Se:		last birthday)		Days Hou	nder 24 Hrs. urs Min.	8. Date of Birt (Month, Da	y, Year)	Cou	place (State or Foreign intry)
	Director		248-58-3573	12	Yrs.				04/04/	193	7 P	uerto Rico
	ou *		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
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0		F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🔼 No						1	Black, White	
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<u>\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ </u>	should be nd Mental marked o	မ	Jose Arroyo				A	dejandri	na Torre	S	T 01-1- 7	i- O- 4-1
<u>a</u>	2 0 - 0		19a. Informant's Name/Relationship (T)				ss (Street and N					ip Code)
d)	of Health Item 27 other tr		Teresa Arroyo/ Daughter 20a. Method of Disposition	20h F	4204	Maryr	ide Driv	e, Nanda	Hstown,	M) 2	L133 cation - City or 1	Town State
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Baltimore, Maryland 21	permit. Page Depertment traportant: It any injury o		21. Signature of Funeral Service Licens	11/1/			and Address of F berty Roa					baro. w.
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Division of Vital	or Al after of Direct in by	Certification:	4 Homicide determined	28e. Place of fnjury - At h building, etc. (Speci		reet, racti	огу, опісв		City or To	wn, State	)	nar rioute runibes,
_	pltal		29a. Certifier 12 Certifying Phy	rsician: To the best of my kno	owledge deat	h occurre	ed at the time, da	ate and place.	and due to the	cause(s)	and manner as	stated.
	24 hos 24 hos Fun etely	Medical		iner: On the basis of examina and manner stated.								
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	₹	29b. Signature and title of certifier			2	9c. License nun	nber		29d. Da	te signed (Mont	h, Dey, Year)
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	_		30. Name and address of person who o		m 23a) (Type,	Print)	027	000			7	
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3.	Regist	rar	OCT 0 7 2009	7 8	6							

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year 351M 4c. County of Death **Physician** Dorothy Mae Appel /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 8. Date of Birth (Month, Day, Y June 29, lace (State or Foreign , 1945 Maryland **Funeral** Min. Days Months 1 □ M 2 🔀 F 64 212-46-0182 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Middle River Maryland Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21220 1208 Fuselage Avenue **Funeral** 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2XXXNo Specify Specify: White ģ 3 Widowed 4 Divorced Completed 16h Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Darcas Cass Lindsey Spear 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1208 Fuselage Avenue, Baltimore, Maryland 21220 Department of Health a Important: If Item 27 is any Injury or other trainonce. Ted Appel, Sr. (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1XD Burial 2 ☐ Cremation 3 ☐ Removal from State Bel Air Memorial Gard 10/07/2009 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 21. Signature of Funeral Service License 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imm if te Cause (Final discusse or condition routing in death) Physician /Medical Due to (or as a consequence of): hemic Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 □Ectopic pregnancy Year Day Month in the past 12 months?
1 ☐ Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2X No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 ☐ No 1□ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 🗖 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No

P.O. Box 68760, Records,

attending physician and for use as the burial-trar

page 2 should be detached

iral", or items 23a or 28a-f sh Examiner must be notified

nit. Pages 1 and 2 should be filed within 72 hours after i artment of Health and Mental Hygiene. ortant: If Item 27 is marked other than "natural", or itel Injury or other traumatic event, the Medical Examiner

The law requires that the death certificate be executed Division or Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p Japital c.
4 hours after des.
reral Director; A'
in by the

Registrar

29b. Signature and title of certifier

29c. License number

iquare Drive

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

es 00000

Baltimone, Md

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000 Frank GoodMa

31. Date filed (Month, Day, Year) OCT 0 7 2009

6 ☐ Could not be

determined

2 Accident

4 Homicide

3□ Sulcide

29a. Certifier (Check only

32. Registrar's Signature

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2005 Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ October 200<sup>yea</sup> 11:30PM Allen Dorothy Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Howard Laurel 10548 Gorman Road Birthplace (State or Foreign Country)
 Tours If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Social Security Number 7. Age (In yrs. last birthday) **Funeral** October 12 Hours 1 □ M 2 🗓 F Months Min. Iowa Director 478-50-5643 70 Yrs. Usual Residence of Decedent 28a-f show 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State should be filed within 72 hours after death with the Maryland and Mental Hyglene. is marked other than "natural", or items 23a or 28a-f sho aumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Howard Laurel 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country? Funeral U.S.A. 10548 Gorman Road 20723 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces Black, White, etc. ò 1 Never Married 2 K Married ☐ Yes 2 🗶 No Maryland 21215-0036 1 Yes 2xx No Specify: If Yes, Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Director of Human Resources Department of Defense Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဥ Fannie Riecke Charles Turner other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar. Important: If item 27 is any injury or other trau Laurel, Maryland 20723 Dale Allen (Husband) 10548 Gorman Road Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1XX Burial 2 ☐ Cremation 3 ☐ Removal from State Arlington National Cemetery 11-13-2009 Arlington, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Service Licenses 5555 Twin Knolls Road Columbia, Maryland 21045 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Gliublistums Physician muntle disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions Examine if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) signed by the a 1 Yes 2 M 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed been si should I 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autope performed has page 2 1 ☐ Yes 2 ☐ No in 24 hours after death.

the Funeral Director: After this certificate I

pleted filled in by the funeral director, pag Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 A Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 1 Yes 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

State

Registrar

within 2
To the I
complete

(Check

Nicholas

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29b. Signature and title of certification

M(S

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kontrelako

Medical Examiner: On the basis of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

38866

Charter Drive Suite 6020

29c. License number

29d. Date signed (Month, Day, Year)

Columbia, MI)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1, Gladys Marie Alston 2009 October 10:00a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 160 N. Post Road Aberdeen Harford ADELUCE:

If Under 1 Year If Under 24 Hrs. 8. Date of Birth

Months Days Hours Min. (Month, Day, Month, Day)

June 14, Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year 1 □ M 2 🛛 F 1934 North Carolina Director 75 239-54-8183 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County fshow event, the Medical Exactner must be notified at 1 XYes 2 ☐ No Director Maryland Harford Aberdeen 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or 160 N. Post Road items 23a 21001 USA by Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ∐Yes 2√ No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 'natural", or 1 □Yes XXNo Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) than, Elementary/Secondary (0-12) College (1-4or 5+) 12 home maker in home h and Mental Hygie be filed v 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should? Floyd W. McKinnev Savanah Slagle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health of Health 27 is John Alston (husband) 160 N. Post Rd., Aberdeen, MD 21001 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages Department of Important: If Its any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 10/6/09 Aberdeen, MD 21. Signature of Funeral Service Light 22. Name and Address of Facility Aberdeen, MD 21001-3399 Funeral Home, P.A. 23a. Part 1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAZ **Physician** DYSMITHTUP 1 MINUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner JAIA FIBALL FISHUMO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Exami burial-transi AURTIC STEWASIS Due to (or as a consequence of): physician Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy for Month Year Day signed by the at d be detached for 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has autopsy performed' 1 □Yes 2 ☑No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Division 1 ☐ Yes 2 ☐ No death. after death 2 Accident filled in by the 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 103 BANA AUR SUE A BERGATINE BIRNGAVA

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			For State Registrar	State of Maryland	•	rtment of H			iene <sub>eg. No.</sub> ? ()	10	12053
	Physicia	an	1. Decedent's Name (First, Middle, Last) Michelle Bittner					2. Date of Dear Month	th Day	Year	3. Time of Death 12:50 pm
	/Medic Examin		4a. Facility Name (If not institution, give s	treet and number)		4b. City, Town, or		<u>lOctober</u>	4c. County	of Death	1
			Northwest Hospital  5. Social Security Number 6. Sex	7. Age (In yrs. la	st birthdav)	Randalls		s. 8. Date of Birth	Balti	9. Birthr	place (State or Foreign
	Funeral Director		183-42-8882 <sup>1□</sup>	M 2⊠F 58	Yrs.	Months Days	Hours Min	8. Date of Birth Month, Day 11/22/1	950	PA	ntry)
	yland now		Usual Residence of Decedent  10a. State 10b. County		Town or Loc	cation				1	0d. Inside City Limits
	he Mar 28a-f sl ctifical	ector	MD Baltimore	e Gwyr	n Oak	10f. Zip Code			0g. Citizen of	Mhat Cour	1 ☐ Yes 2 No
	h with t	al Dir	10e. Street and Number 7519 Windsor Mill H	Road		21244			USA	Wilet Godi	
36	be filed within 72 hours after death with the Maryland Ital Hygiene. d other than "natural", or items 23a or 28a-f show event, I're Medical Expirit in I. ust by notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1	1	Was Decedent of H fYes, specify Cuba I∐Yes 2XDNo	ispanic Origin? ( In, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Bla	14. Race - American Indian, Black, White, etc.  Specify: White	
215-UU36	thin 72 hour re. ran "natural Medical E	Completed I	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	(Give life. L	dent's Usual Occup kind of work done o DO NOT use retired	during most of wo l)	orking	16b. Kind of B	Secu	rity
17 D	filed wi Hygier <b>sther th</b> ent, Ille		17. Father's Name (First, Middle, Last)	2	Claim	s Investi		ame (First, Middle,			ation
yland	12 should be filed v h and Mental Hygie 7 is marked other t traumatic event, "I	To Be	Nazareth J. DeMar	20				C. Soos			
Mar	ind 2 sho alth and 27 is ma er trauma		19a. Informant's Name/Relationship (Type William Bittner, h		19b. Mailir 7519	ng Address (Street Windsor N	and Number or F $111  \mathrm{Rd}$ .	Rural Route Numbe Gwynn Oa	r, City or Town ik, MD	, State, Zij 21244	o Code)
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Menta Important; If item 27 is marked any injury or other traumatic es once.		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Re  4 □ Donation 5 □ Other (Specify)		metery, cren 1er Fa	sition (Name of natory or other place 11s Cemet	ery 10/	Date 6/2009 I	20c. Location Beaver	Falls	, PA
Ball	permit. Departi Imports any inji		21. Signature of Funeral Service License		9	33 Gist A	Ave. Sil	pp Funera ver Sprin	ng, MD	emati 20910	
	Dhusisian		23a. Part 1. Enter > disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		W 8 :	2 3	ac or respiratory an	rest,		Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a consequ		Lung a	Men				
Λ		ner	Sequentially list conditions, cause. Enter Underlying	Due to (or as a conseru	ence of						
b' o	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	ence of):						
<b>68/6</b> 0	ficate by physic s the bu	edical	d								
. Box	ne death certificate the attending phys hed for use as the	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregnar 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3[	Ectopic pregnand Other <i>(specify)</i> _	у			ate of deliventh	very Day Year
7.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions con	tributing to death but not resu	Iting in the u	nderlylng cause giv	en in Part I.		obacco use cor 'es 2 ☐ No		the cause of de ?
Hec	The lar ate has age 2	Completed		<u> </u>				24a. Was autop perfor 1 🗆 Yes	sy /	Were autoprior to codeath?	opsy findings available ompletion of cause of 2 \(\hat{\texts}\) No
Vital	/sician: s certific director,	o Be (	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ Wo	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 🗆 DOA Oth		eath <i>(Check only o</i>		n-pat her (Spec	ient hospice
n of	iding Physician: th. After this certifical funeral director,	ion: T	27. Manuar of Death  1 Value 1 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	f 28c. Injui Wor	y at	28d. Describe h			
DIVISION	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director. After this certifica completely filled in by the funeral director.	Certification: T	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str		res 2 🗆 No	28f. Location (S City or Tow	Street and Num n, State)	ber or Rui	ral Route Number,
	e Hospita 24 hours Funeral etely fille	Medical C	29a. Certifier 1 Certifying Phys (Check only one) 2 Medical Examin	sician: To the best of my knowner: On the basis of examination and manner stated.	wledge, deat tion and/or in	h occurred at the ti	me, date and pla opinion, death oc	ace, and due to the courred at the time,	cause(s) and r date and place	nanner as , and due	stated. to the cause(s)
	To the within To the complete	Me	29b. Signature and title of certifier  NS κώμρακ	em·D-			00574			0/1	109.
7	Þ		30. Name and address of person who co	mpleted cause of death (Item	23a) (Type, Main S	Print) t. ) Suite	200,	Reisters	town	, MD	. 21136.
	Sta Registr		31. Date filed (Month Pay Year 2009	Registrar's Signar	ire do	AL.					

DHMH 17 Rev 1/2001

			1 - For State Registrar		of Maryla	-		of He	ealth an	d Men	tal Hyg	eg. No.	9	32057
	Physici	an	Decedent's Name (First, Midd								Date of Deal		'eer	3. Time of Death
7	/Medic	al	Valerie	C.		B	ryant				tober	2, 2009		2:00 a M
7	Examin	er	4e. Fecility Name (If not institution	n, give street and	number) -				Location of D	eath		4c. County of		
			Prince Georges				-	ever	⊥y If Under 24	Hrs or	lata of Birth	Prince		orges  place (State or Foreign
	Funeral	l i	5. Social Security Number	6. Sex 1 ☐ M 2 1 F		. last birthday) Yrs.		Days		Vin. Ta	Date of Birth Month, Day n. 26	Year) 1943 W	Cour	ington, DC
	Director		578-56-8605 Usuel Residence of Decedent		00	)	LL.			υα	11. 20	, 1 ) 3 N	2011	ingcom, so
	yland		10a. State 10b. Count	/	10c. C	ity, Town or Lo	cation						1	10d. Inside City Limits
	Mar fied	to	MD P.	G.	1	oistric	t Heig	hts						1∰Yes 2□No
	death with the Maryland me 23a or 28a-f ehow rmust be notified at	Funeral Director	10e. Street and Number				10f. Zip C	ode			1	0g. Citizen of Wh	at Cou	ntry?
	th will	a D	2026 Oakwood La	ne			2	0747	7			U.S.A	•	
	dea E	ner	11. Marital Status	12. Was D	ecedent Ever in I Forces?	U.S. 13.	Was Decede	nt of His v Cuban	panic Origin , Mexican, P	? (Specify uerto Rica	Yes or No- n, etc.)		Americ White,	can Indian, etc.
98	or its	J. F	1 Never Married 2 Ma	rned 1 □ Ye	s 2∕∏ No Give		1 ☐ Yes 2		Specify:			Specify:		
8	urel',	d by	3 Widowed 4 Divorce	3 Year o	r Dates:	10.0								
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12	withir ene. then	E C	Elementary/Secondary (0-12)	College	9 (1-4or 5+)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Dome					Priv	ate	
9	Hygi Hygi other	ပိ	17. Father's Name (First, Middle	, Last)					18. Mother's	Name (Fil	st, Middle,	Maiden Sumame	)	
an	d be ental ked c	To Be	Thomas		Jer	nkins,	Sr.		Hele	en			Alle	en
Maryland 21215-0036	shoul nd M mari	-	19a. Informant's Name/Relation	ship (Type, Print)				Street ar			ute Number	r, City or Town, S		-
	nd 2 alth a 27 io		Jacqueline West	- Daugh	ter	33 W	hitest	one	Dr.,	Staff	ord,	Virginia	2:	2556
ē,	s 1 a of Hea item othe		20a. Method of Disposition		20b.	Place of Dispo				Date		20c. Location - C		own, State
E	Page nent c int: #		1 🖾 Burial 2 □ Cremation  4 □ Donation 5 □ Other (			armony				-09-2	009	Landover	, Ma	aryland
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "naturel", or iteme 23s or 28s-f show may injury or other traumatic event, the Medical Examiner must be nutified at ODGs.		21. Signature of Funeral Service	Licensee	\	2:	2. Name and	Address	of Facility	Ronal	d Tay	lor II F	une	ral Home
ω_	88 3 5 8		Koonald	- copy	AT.	1	0583 M	idd]	leport	Lane	, Whi	te Plain	s, I	Md. 20695
	Physician /Medical Examiner		23a. Part1. Enter the disease, c shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	a. End	n each line.  Stage I to (or as a conse	Lung Ca		or dying	, such as car		spiratory arr	est,		Approximate Interval Between Onset and Death
20928	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	dicai Examiner	if any, leading to immediate cause. Enter Underlying Cause, Disease or injury that initiated events resulting in death) Last	<b>1</b>	to (or as a conse									
P.O. Box 68	Attending Physician: The law requires that the death certifical refeath. sctor: Atter this certificate has been signed by the attending phy by the funeral director, page 2 should be detached for use as the	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown	1□Liv 4□Pro	outcome of preg e birth 2 Fe egnant at time of known	tal death 3	□Ectopic pre					23d. Date Mont		ery Day Year
rds, F	equires that an signed ould be de	ed by P	Part II. Other significant condit	ions contributing to	death but not re	esulting in the u	inderlying cai	ısə givər	n in Part I.					the cause of death? bably 4 \text{Munknown}
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ū	ding P. h. After i	on:	27. Manner of Death 1 XNatural 5 ☐ Pend	11.5	te of Injury Ionth, Day Year)	28b. Time o		c. Injury Work			Describe h	ow injury occurre	d	
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Ξ	or At after of Direct in by	Certification:	4 Homicide deter	minor   200. Pi	ace of Injury - At ilding, etc. (Spec	nome, tarm, st cify)	reet, lactory,	office		201.	City or Tow		or nur	al Route Number,
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	edical Ce	29a. Certifier 1 Certify (Check only one) 2 Medica	ing Physician: To I Examinar: On the and m	the best of my kr e basis of examination	nowledge, dear nation and/or in	h occurred a	t the time	e, date and p inion, death	place, and occurred a	due to the d t the time, d	ause(s) and man date and place, ar	ner as s	stated. to the cause(s)
	Nithin To the	Me	29b. Signature and title of certific	er					number		2	29d. Date signed	(Month,	Day, Year)
	- > PH ()			1-01	lixcim			00	684	-39		10,2	, 0	9
	1,		30. Name and address of perso	n who completed c	ause of death (Ite		Print)							
	H		Dr. Ziba Shi	rani - 30	001 Hosp	ital D	rive, (	Chev	erly,	Mary]	and 2	0785		
	Sta		31. Date filed (Month Day, Year OCT 0 7 20	09 / 32	. Registrar's Sign	nature	1							
	Registi	ar		1	-	1971								

	CX
Il Records, P.O. Box 68760,	n: The law requires that the death certificate be executed
or Vita	Physician:
Division or Vital	Hospital or Attending Physician:
	lospital

	1	State Registrar  Decedent's Name (First, Middle, Last,	)	Ce	ertificate of	Death	Re 2. Date of Death	g. No.	3. Time of Death
sician	1	Elizabeth W. Bran					Septemb	Day	Year 2009 8:25 AM
ledical aminer		a. Facility Name (If not institution, give			4b. City, Town, o	Location of Death			ty of Death
		Charlestown Healt	h Center		Catons	/ille			timore
eral	5	i. Social Security Number 6. Sec		n yrs. last birthday	If Under 1 Year   Months   Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Mar 20,	Year)	Birthplace (State or Forei Country)
tor	l	215-28-0598  Usual Residence of Decedent	JM 2∏ F {	81 Yrs.			Mar 20,	1928	Maryland
To la	1	Oa. State 10b. County	10	Oc. City, Town or L	ocation				10d. Inside City Limi
S	2	MD Baltimore	2	Caton	sville				1 □Yes 2√
event, the Medical Examiner must be notified at		Oe. Street and Number 719 Maiden Choice	Lane RD51	2	10f. Zip Code 212	228	10	g. Citizen o USA	of What Country?
nust or o			12. Was Decedent Eve				pocify Vac or No.		ace - American Indian,
Finoral	֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	Marital Status     □ Never Married 2  Married	Armed Forces? 1 ☐ Yes 2 [X] No	1111 0.5.	. Was Decedent of H If Yes, specify Cuba	an, Mexican, Puert	o Rican, etc.)		lack, White, etc.
Xam	2	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>X</b> No	Specify:		Spec	eify: white
r, the inedical b		15. Decedent's Edu (Specify only highest grad	ication	16a. Dec	edent's Usual Occup	ation	king	6b. Kind of	Business/Industry un
mule		Elementary/Secondary (0-12)	College (1-4or 5+)	life.	e kind of work done DO NOT use retired	1)	9		
			1	se	cretary	19 Matharia Nor	ne (First, Middle, M	Inidan Cura	amal
even a	ŏ	17. Father's Name (First, Middle, Last)  John Alexander	Worthington	n		Elizabe		aluen sum	amej
L L		19a. Informant's Name/Relationship (Ty			ling Address (Street			City or Tou	un State Zin Code)
To Be Comm	- 1	Charles Brandt/spo							sville, MD 2122
James	-	20a. Method of Disposition		20b. Place of Disp	osition (Name of	i			n - City or Town, State
yor		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☑ Donation 5 ☐ Other (Specify)		cemetery, cr	ematory or other pla	ce)			
any injury or conce.		21. Signature of Euneral Service Licens		+	22. Name and Addre	ss of Facility	4 655 M	Do1+1	more Street
ang onc		Konard S.	Vade Direc		altimore,			Dalti	more street
		23a. Part1. Enter the disease, or compleshock, or heart fallure. List only o	lications that caused the	e death. Do not e	nter the mode of dyir	ng, such as cardiad	or respiratory arre	st,	Approximate Interval Between
ian		Immediate Cause (Final disease or condition	nie dadse on daon inte.		emente	1			Onset and Death
cal		resulting in death)	a Due to (or as a c		20100				
ner		Sequentially list conditions	b						
	<u> </u>	Sequentially list conditions,	Due to (or as a c	onsequence of):					
100		if any, leading to immediate cause. Enter Underlying							
-transit	E E	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	oncognopoo of):					
ourial-transit	EXa	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	onsequence of):					
	al Exa	that initiated events	c	onsequence of):					
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Tor use as the but	al Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	Due to (or as a c	pregnancy □ Fetal death 3	□Ectopic pregnanc:	y			Date of delivery Month Day Year
Tor use as the but	al Exa	resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant	Due to (or as a c d	pregnancy □ Fetal death 3		9			,
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pletery filled in by the funeral director, page z should be detached for use as the but better the but by by continuous to be but by by continuous to be completed by by circum. To be completed by by circum and continuous to be but by by circum and continuous to be but by but by but b	legical Certification: To be Completed by Physiciatriwedical Exa	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	Due to (or as a cod.  Due to (or as a cod.  23c. If yes, outcome pf 1 Live birth 2 Live birth 2 Live birth 2 Live birth 3 Live but nontributing to death but no live birth 3 L	pregnancy Fetal death 3 ne of death 5 not resulting in the 22 ER/Outpati 28b. Time Injury At home, farm, s Specify)  my knowledge, de kamination and/or	Other (specify)  underlying cause give  ent 3 DOA Other  of 28c. Inju Wo M 1  etreet, factory, office  ath occurred at the ti investigation, in my	26. Place of Dealer: 4 Nursing Hry At Yes 2 No	24a. Was an autops perform 1 Yes 2 ath (Check only one 5 Reside 28d. Describe house 28f. Location (St. City or Town a, and due to the courred at the time, d	acco use constant and selection and selectio	Month Day Year  contribute to the cause of death?  3 Probably 4 Unkno  b. Were autopsy findings availa prior to completion of cause of death? 1 Yes 2 No  Other (Specify)  curred  manner as stated.  ce, and due to the cause(s)
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State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 10 11:15 AM BRIDGES COTHERINE /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE, MO BALTIMORE UNIVER SITY SPECIALTY HOSP 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Min 1 □ M 2 🔀 F 60 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 28a-f show Department of Health and Mental Hygiens "ratural", or items 23a or 28a-f show Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 es 2 No Director Imore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2,2 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore, Maryland 2121 FACTORIES Elementary/Secondary, (0-12) WORKER ACTORY Sth 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) moore mes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type. Print) Denise 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematoru Date 20a. Method of Disposition Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-10-09 23a. Part First the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart failure. List only one cause on each line.

Immediate, ause (Final disease in condition resulting in death)

a. PSPIRATION 4 □ Donation 5 □ Other (Specify Approximate Interval Between Onset and Death **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) attending physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy 2 No certificate funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 ☐ Yes this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fo 6 ☐ Could not be determined 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital of within 24 hours af To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/03/09 D66195 30. Name and address of ersor who completed cause of death (Item 23a) (Type, Print)

Registrar

31. Date filed (Month, Day, Year

NGUYEN 725 W LOMBARD ST 32. Registrar's Signature

BALTIMORE, MD 2/201

			For State Registrar	State of M	arylan	•	artment of H rtificate of L		and M		iene eg. No. (	2009	32060
	Physici	an	1. Decedent's Name (First, Middle, L							2. Date of Deat Month	th Day	Year	3. Time of Death
	/Medi		Michael		fler					October	2,	2009	12:15A <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, g	· · · · · · · · · · · · · · · · · · ·			4b. City, Town, or		f Death			ounty of Death	n
-			165 North East 5. Social Security Number 6.			14 E/-4E 1	North E		D/ Hre T	0 Date of Birth	-	cil	nplace (State or Foreign
	Funeral Director		638-06-7718	1 <b>½</b> M 2 □ F	89	last birthday) Yrs.	Months Days	Hours	Min.	8. Date of Birth (Month, Day, 12/21/	Year) 1919	Col	many
and	MC +		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside City Limits
Maryl	f she	ō	MD Cecil		Nor	th Eas	st						1 ☐ Yes 2 ☐ No
the	r 28a	Director	10e. Street and Number				10f. Zip Code			1	0g. Citize	n of What Co	untry?
h wit	23a o	aD	165 North East	Isles Driv	re		21901				Ge	ermany	
deat	ems (	Funeral	11. Marital Status	12. Was Decedent Armed Forces	Ever in U.	S. 13.1	Was Decedent of Hi f Yes, specify Cuba	ispanic Orig	gin? (Spe	ecify Yes or No-	14	. Race - Amei Black, White	
21215-0036 d within 72 hours after death with the Maryland	giene. r than "natural", or items 23a or 28a-f show If e Madical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced				1 □Yes 2⊠No	Specify:	, r derio	riiodii, cio.)	S	NATA TELE	ite
5-0 2 2 5	natur	Completed	15. Decedent's (Specify only highest of	Education		16a. Dece	dent's Usual Occupa	ation	of worki	200	16b. Kind	of Business/I	ndustry
vithin 7	nan "r Mad	nple	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT use retired	)	OI WOIKI	ng	Cho	ese Pl	on t
d 21 filed wi	Hygier ther the		12			Owr	ed Busin						.ali C
(h)	- 0 W	To Be	17. Father's Name (First, Middle, Last Josef	st)		Bufl	ler	18. Mother		(First, Middle, I	Maiden Su	urname)	Losch
<b>1ar</b> . 2 sho	ls mg		19a. Informant's Name/Relationship				ng Address (Street a				-		
and and	m 27 her tr		Cynthia S. L. Es	tes/ Daugh									MD 21901
Ore Jes 1	ment of hant: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3	☐ Removal from State			sition (Name of natory or other place					tion - City or	
<b>#</b>	tant: jury		4 X Donation 5 ☐ Other (Spec	rify) A	Ana	•	fts Registr	4				ær, Ma	
Baltimore, permit. Pages 1 ar	Department of Health and Ments Important: If Item 27 Is marked any injury or other traumatic evence.	8 3	21. Signature of Edheral Service U	ensee			Name and Address 22 Conne						
8760, ate be executed	physician and Medical caminer sthe prival-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Either Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or as  b. Due to (or as  c. Due to (or as	5				Onset and Death Unlemm				
O. Box 6	y the attending p ched for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   9   Unknow								23	ivery Day Year	
rds, P.	been signed by the should be detached	by	Part II. Other significant conditions Cereber	contributing to death to		ulting in the ur Accia		en in Part I.			bacco use		the cause of death?
<b>O</b> N	s bee shou	lete								24a. Was a	n	24b. Were au	topsy findings available
al Re	icate has page 2 s	Completed								autops perforr 1 □ Yes	med?	prior to death? 1 ☐ Yes	completion of cause of
VII	certif	Be	25. Was case referred to medical examiner?	Hospital:			Otho			(Check only on			
P Pyg	r this ral dii	2	1 ☐ Yes 2 X No  27. Manner of Death	1 Inpati		ER/Outpatier 28b. Time of		4 🗆 1401		me 5 Reside			cify)
o all b	h. After fune	ţi	1 Natural 5 ☐ Pending	(Month, Da	ay, Year)	Injury	Work	γαι ? Yes 2∐N		zou. Describe no	ow injury (	occurred	
5 5	after deat <b>Director:</b> I in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not determine	be 28e. Place of In	jury - At ho tc. <i>(Specif</i> )	me, farm, stro	eet, factory, office	100 12.		28f. Location (St City or Town	treet and i	Number or Ru	ıral Route Number,
Div To the Hospital or	within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	edical C	29a. Certifier 1 Certifying F (Check only one) 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examinat	wledge, death tion and/or in	n occurred at the tin vestigation, in my o	ne, date an pinion, deat	d place, th occurr	and due to the cred at the time, d	cause(s) a late and p	and manner as lace, and due	s stated. to the cause(s)
To the	within <b>To th</b> compl	Me	29b. Signature and title of				29c. License	number		2	9d. Date	signed (Monti	h, Day, Year)
	~ F 0		Saor	iclev 8n	11)		1 29	3322			10	.2.20	09.
				DEV MD	death (Item	123a) (Type,	29c. License  D 25  Print)  F High	g St	E	eston	M	0219	72/
	Sta Registr		31. Date filed (Month, Day, Year)	32 Registr	rar's Signat	ture	a dad						

1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 6.20 gm Lee Brown Sr. 2009 04 October Percy /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner baltimore SnaiHospetal of Baltimone If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months X□ M 2□ F Yrs. 424**-**52**-**8363 10 02 41 AL Director 68 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the thirding Evandor is ust be notified at Y☐Yes 2☐No Baltimore Director MD NA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21207 U.S.A. 3702 Howard Park Ave Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 3 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ▼No Specify Specify: Black ò 3X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Bethlehem Steel Steel Worker 12th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Katie Rodgers Essie Brown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 to Department of Health an Important: If fleen 27 is many injury or other 2 once. 19a. Informant's Name/Relationship (Type. Print) 2<u>11</u>33 Randallstown, 9410 Paintedtree Drive, Percy Brown Jr.-Son Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition MD Burial 2 Cremation 3 Removal from State 10/9/09 Woodlawn, Md Woodlawn 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign the of Funeral Service Libensee March F/H West 21215 Md Thompson 4300 Wabash Ave, baltimore, 23a. Part 1. I ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line.

Immediate Chise (Final Approximate Interval Between Onset and Death 15 day **Physician** Rupture of abdominal actic disease or condition resulting in death) /Medical (or as a consequent of): **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): physician s the burial Box 68760. attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4 ☐ Pregnant at time of death 5 Other (specify) o the 9 Unknown 9 Unknown signed by t t be detach ₫. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown myeloma, Non smallcell s been si should I 24b. Were autopsy findings available prior to completion of cause of death? diabets 24a. Was an hypertemion, cate has l page 2 s performed? certificate 1 ☐ Yes 2 ☐ No 2 No 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) director Be Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 🕱 No Certification: To After th funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No hours after death. investigation 2 Accident I Director: 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours are
To the Funeral Dir 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only one) and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number RES 000 Autober 04 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) of baltimore, 2401 Belvedere avenue, Bultimpe Sinai hospital MD, Pillai MD-21211 State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Months

10f. Zip Code

1 ☐ Yes 2√2 No

16a. Decedent's Usual Occupation

7. Age (In vrs. last birthday)

10c. City, Town or Location

Baltimore

59

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:

College (1-4or 5+)

i icasc i	ype of 1 fillt ill black illdelible link. Ellouie A	ii oopico Aic Ecgibic.	
r	State of Maryland / Department of Health and N	Mental Hygiene	00000
ate egistrar	State of Maryland / Department of Health and N  Certificate of Death	Reg. No.	32001
edent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
Phyllis	Brown	oct. 3,2009 Year	2:55Ma

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Hours

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Specify:

Min.

Baltimore

Days

21206

(Give kind of work done during most of working life. DO NOT use retired)

housekeeping

4c. County of Death

10g. Citizen of What Country?

14. Race - American Indian, Black, White, etc.

Johns Hopkins Hosp.

21213

several years

Year

Specify: Black

16b. Kind of Business/Industry

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 【★No

Month

USA

Birthplace (State or Foreign Country) MD

10d. Inside City Limits

1 ☑ Yes 2 ☐ No

n/a

8. Date of Birth (Month, Day, Year) Feb. 7, 1950

18. Mother's Name (First, Middle, Maiden Surname)

2713 Hanson Ave. Apt. 1D Balto, Md. 21209

Ineal Edmonds

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

**Physician** /Medical Examiner 1. Dec

10a State

MD

4a. Facility Name (If not institution, give street and number)

10b. County

n/a

6. Sex

Shamrock Ave.

15. Decedent's Education (Specify only highest grade completed)

Wormley

Stephanie Brown (daughter)

1□M 2□F

4353 Shamrock

1 Never Married 2 Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

17. Father's Name (First, Middle, Last)

19a. Informant's Name/Relationship (Type. Print)

12th

Ervin

5. Social Security Number

218-54-0709

Usual Residence of Decedent

10e. Street and Number 4353

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or items 23a or 28a-f show Examiner must be notified at Director

Baltimore, Maryland 21215-0036

Funeral

à

Completed

Be

ပ

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Records. Division of Vital death.

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 6,20d9 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Oct. injury or Balto, Md. 21. Signature of Funeral Service Licenses <sup>22</sup> Name and Address of Facility Calvin B: Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Breast Concer **Physician** Metastatic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, in your sequentially cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24a. Was an 1 □Yes 2 XNo 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death uneral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours 29a. Certifier (Check only within 2 To the 29b. Signature and title of certifier 29c. License number D40277 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DY BYD State

🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 5601 Loch Raven Blud, Baltimore, mp 21239 Registrar **ORIGINAL** 

Physician /Medical

Examiner

**Funeral** Director

	Please Ty	ype or Prin	it in Black	Indelib	le Ink. Ensure	All C	Copies Are	Legible.	
For State			aryland / D	epartme	ent of Health and		ntal Hygien	9	
Registrar	- (Flunk kildelle 1 - 1)			Jertifica	ate of Death	1.0	Reg. No	· 201	9,32053
Ralph	e (First, Middle, Last)	nt Cha	se, Sy	<b>^.</b>			Date of Death Month Da	Year	3. Time of Death 4:02 PM
4a. Facility Name (/	If not institution, give s	treet and number)		4b. Cit	ty, Town, or Location of De			. County of Dea	ath
Sina	hoso)	tell o	of Balti	more !	Baltimore	C	ity	N	<i>IA</i>
5. Social Security N 579 • 50 •		M 2□F 7. Age	(In yrs. last birth	rs. If Unc	ler 1 Year   If Under 24 H s Days Hours Mi		Date of Birth (Month, Day, Year )4 5 9 3	9. Bit	rthplace (State or Foreign ountry)
Usual Residence of 10a. State	Decedent 10b. County		10c. City, Town	or Location		-			10d. Inside City Limits
MD	Baltim	No.		4 41	stown				1 □Yes 2 No
10e. Street and Nur		u o	7Cu	<u> </u>	Zip Code		10g. C	tizen of What C	, ,
9708	Kemigan	Court		101.2	21133		1.03.0	USA	,
11. Marital Status		2. Was Decedent E		13. Was Dec	cedent of Hispanic Origin?	(Specif	y Yes or No-	14. Race - Am	
	ied 2 Married	Armed Forces? 1 Yes 2 □ N	lo	If Yes, sp	pecify Cuban, Mexican, Pu	erto Ric	an, etc.)	Black, Whi	te, etc.
3 Widowed		If Yes, Give Year or Dates:		1 ∐ Yes	2 No Specify:			Specify: 2	lack
(Spec	15. Decedent's Educatify only highest grade	ation completed)	1	Give kind of v	sual Occupation work done during most of w	vorking		(ind of Business	
Elementary/Seco	ondary (0-12)	College (1-4or 5-		life. DO NOT	use retired)		Ba	Umpre	: 1
12-10 90 17. Father's Name	(First Middle Last)	4 years		super	intendent	lame /F	irst, Middle, Maide	1 1010	attony
Martin	Chase				Mary	Ba	în N	r ourname <sub>j</sub>	~
19a. Informant's Na	ame/Relationship (Typ	e. Print)	19b. I	Mailing Addre	ess (Street and Number	Rural R	oute Number, City	or Town, State,	44
Belly B.	chase,	MITO	14	108 K	errigan (	iou	rt Kar	dallsto	NA MD21133
20a. Method of Disp	position □ Cremation 3 □ Re	amoval from State	20b. Place of I	Disposition (A crematory o	lame of control of the place)	Date		ocation - City or	
	5 ☐ Other (Specify)	movai nom State	MOON	awn	Cemetery Id	101			n, MD
21. Signature of Fu	uneral Service License	الأ		22. Name	and Address of Facility	gu Po	in C.Gr		neral Senico Un MD 21133
23a. Part 1. Enter t	ne disease, or complic	ations that caused	the death. Do no	ot enter the m	ode of dying, such as card	liac or re	espiratory arrest,		Approximate Interval Between
Immediate Cause		24	ation	0.561	umonia				Onset and Death
disease or condition resulting in death)	a.		a consequence of	_	~ · vig rilloc				lang
			,		a stomach	r			1 year
Sequentially list contains, reading to im- cause. Enter Under Cause (Disease or	nditions, b.		a consequence of						
that initiated events	6 C.								
resulting in death) I	Last	Due to (or as a	a consequence of	):					
	d.								
IF FEMALE:									
23b. Was decedent	t pregnant	Sc. If yes, outcome of		3 🗆 Ectopie	c pregnancy			23d. Date of de	
in the past 12	□No	4 ☐ Pregnant at 9 ☐ Unknown		5 Other				Month	Day Year
9 Unknown			4 4 4 1				Ogo Didtobas	una partituit	to the eques of death?
	etensions cont	^		ne underlying	g cause given in Part I.	1600			to the cause of death?
- ry pe	~10013111	, Aner	, the same	um	may amoor	-12.04	1 ☐ Yes 2	- INO 3[X]	robably 4 Unknown
						_	24a. Was an autopsy	24b. Were a	autopsy findings available ocompletion of cause of
							performed? 1 ☐ Yes 2 ☑ N	death?	
25. Was case refer examiner?	/	1			T	Death (C	Check only one)		
1  Yes 2	140	ospital: 1 Inpatie			DOA Other: 4 Nursing	g Home	5 Residence	6 ☐ Other (Sp	ecify)
<ol> <li>Manner of Deat</li> <li>Natural</li> </ol>	5 Pending	28a. Date of Injur (Month, Day	ry 28b. Ti <i>r, Year)</i> Inj	ury	28c. Injury at Work?	280	I. Describe how inju	ury occurred	
2 Accident	investigation 6 ☐ Could not be			M	1 ☐Yes 2 ☐No				
4 ☐ Homicide	determined	28e. Place of Inju building, etc	ry - At home, farr . <i>(Specify)</i>	n, street, facto	ory, office	28f.	Location (Street a City or Town, Sta	ind Number or F te)	Rural Route Number,
						1			4

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at apries. 10a. State Be Completed by Funeral Director MD 10e. Street and N 9708 11. Marital Status 1 Never Ma 3 Widowed (Sp Elementary/Se 2+0 9 17. Father's No. Martin ٩ 19a. Informant's Petry B 20a. Method of D 1 X Burial 4 Donation 21. Signature of Va 23a. Part 1. Ente shock, or h Immediate Caus disease or condi resulting in death **Physician** /Medical Examiner Sequentially list of any, leading to cause. Enter Un Cause (Disease that initiated ever resulting in death Be Completed by Physician/Medical Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed IF FEMALE: 23b. Was deceded in the past 1 ☐ Yes 9 Unknow Part II. Other sig 25. Was case ref 1 Yes 2 Medical Certification: To 27. Manner of De 2 Accident 3 Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 4 2009 19621 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Pandry, M.
31. Date filed (Month, Day, Year) MBBS Maryan Hospital 32. Registrar's Signature State OCT 0 7 2009 Registrar

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** September 29 2009 Regina Ophelia Calaman /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Baltimore fimore Birthplace (State or Foreign Country) Age (In vrs. last birthday Funeral Year 217-12-6707 85 June 5. 1924 Maryland Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylai Department of Health and Mental Hygiene. Important; If Item 27 Is marked other than "natural", or items 23a or 28a-4 shov any injury or other traumatic event, the Medical Exandiant in items to a confident and injury or other traumatic event, the Medical Exandiant. X∑Yes 2 No Maryland N/ABaltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4523 Homer Avenue 21215 USA Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐Yes 2 No Specify ģ 3√2 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) USF&G Insurance Co. Elementary/Secondary (0-12) Clerk 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Delancey Bryant Regina 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ophelia Delores Leverett 3717 W. Garrison Avenue Baltimore, Maryland Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Calvary Cemetery 10/6/09 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Brooklyn, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee 5240 Reisterstown Rd Baltimore, MD 21215 MUNI 23a. Int 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. -2 hes. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical status post right hemi-colectomy **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed' 2 XNo certificate 1 XYes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred

To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by

Registrar

Medical

WEINTRAVB

5 Pending investigation

6 Could not be determined

2 Accident

4 Homicide

(Check only one)

31. Date filed (Month

29b. Signature and title of certifier

3 ☐ Suicide

29a. Certifier

STAFF SURGEON 066810 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated

2435 WEST egistrar's Signature

. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Berverene Avenue

1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Comparison of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2009  $A^{M}$ 9:15 **Physician** Sept. Wei-Ying Κ. Chang /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Rockville Shady Grove Adventist Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday, **Funeral** Months Days Hours 1 M 2 X F 1926 China 83 Feb. 11, Director 467-51-7511 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location iral", or items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director Potomac Maryland | Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20854 11733 Le Havre Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify Specify: Asian þ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Taiwan Government Clerk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zhu Fangyin Zhang Dongchu 9 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11733 Le Havre Dr., Potomac, MD 20854 Florence Tung (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Important: If It any Injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State City of Industry, CA Rose Hills Cemetery 10/3/09 4 Dopation 5 ☐ Other (Specify) 22 Name and Address of Facility Universal Chung Wah Funeral Home 225 North Garfield Ave., Alhambra, 21. Signa re of F neral Service Licen ee CA 91801 Mun Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final 1 Day Respiratory Failure disease or condition resulting in death) Due to (or as a consequence of): 1 Week Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated cause) Due to (or as a consequence of): Examine Years Dementia Physician/Medical

**Physician** /Medical Examiner

the Maryland

within 72 hours after death with

natural"

and Mental Hygiene.

of Health a

permit. Pages 1 Department of Ho

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Baltimore, Maryland 21215-0036

and the burialphysician detached for use as signed by the Completed peen has To the Hospital or Attending Physician: "within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be

Division of Vital Records, P.O. Box 68760

The law requires that the death certificate be

DHMH 17 Rev 1/2001

lical Exa	resulting in death) Last	Due to (or as a consequent of the consequence of the	uence of):				Years
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pregna 1  Live birth 2 Feta 4 Pregnant at time of d	death 3 Ectopi	c pregnancy (specify)		23d. Date of de Month	elivery Day Year
	Part II. Other significant conditions of	ontributing to death but not resu	ulting in the underlying	g cause given in Part I.			to the cause of death? Probably 4XI Unknown
Completed					24a. Was an autopsy performed 1  Yes 2  X	prior to death?	autopsy findings available completion of cause of s 2 \( \square\) No
	25. Was case referred to medical			26. Place of De	ath (Check only one)		
o Be	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 🛣	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence	e 6 ☐ Other (Sp	ecify)
Certification: To	27. Manner of Death  1  Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 □Yes 2 □No	28d. Describe how in	njury occurred	
ertifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specific	ome, farm, street, fact by)	ory, office	28f. Location (Stree City or Town, St	t and Number or i tate)	Rural Route Number,
Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occur ation and/or investiga	red at the time, date and plaction, in my opinion, death occ	ce, and due to the caus curred at the time, date	e(s) and manner and place, and di	as stated. ue to the cause(s)
Me	20h Signature and title of certifier			29c. License number	29d.	Date signed (Moi	nth, Day, Year)

ptember 28, 2009

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who complete

Joel F. Buzy, M.D.

9901 Medical Center Dr., Rockville, MD 20850

cause of death (Item 23a) (Type, Print)

3. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Osborne K. Diggs SEPTEMBER 25,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE St. AGNES HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year | 12-18-1929 | 12-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-1929 | 13-18-19 9. Birthplace (State or Foreign 5. Social Security Number Sex 1X M 2□ F 7. Age (In yrs. last birthday) **Funeral** 225-61-2398 79 Yrs. Libería Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location show d other than "natural", or Items 23a or 28a-f sho event, the Medical Experience is ust be notified at Yos 2 □ No Baltimore Director MD 10e. Street and Number 10g. Citizen of What Country? USA 647 Brisbane Rd. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2X Married altimore, Maryland 21215-0036 1 ☐ Yes 2X No Black Specify: \$ 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) National Archives Center Deputy Director General permit. Pages 1 and 2 should be filed a Department of Health and Mental Hygin Important: If Item 27 is marked other any Injury or other traumatic event, If 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Manoballah Ciata Charles Diggs 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 647 Brisbane Rd. Baltimore, MD 21229 Eva Diggs/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-10-09 Baltimore, MD Woodlawn Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ronald Taylor II F.H. 10583 Middleport Ln. White Plains, MD 20695 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Intracranial **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Hypertensian YEAV Sequentially list conditions, Due to ( as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) O. Box 68760 Physician/Medical use as attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 2 XNo 1 □Yes 1 ☐ Yes funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending after death. 1 □Yes 2 □No 2 ☐ Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide within 24 hours a

To the Funeral I

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number P23613 Like, Medical Resident SEPTEMBER 25,2009

State Registrar 31. Date filed (Month, Day, Year)

900 Caton Ave Baltimore, MD, 21229 SOM NATH CHALISE 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OCT 0 7 2009



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month, Day Year **Physician** Eptember 76 200 John Albert Duvall /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Seasons Hospice/Northwest Hospital Randallstown 8. Date of Birth (Month Day, Feb 13, Birthplace (State or Foreign Country) if Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday, 5. Social Security Number **Funeral** Days Mary land Hours Min. 1 X M 2 □ F T923 86 Director 216-16-3586 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show Item 27 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the headen Exp. Item must be a differed at t⊈Yes 2□No Director MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 21207 USA 3605 Hicks Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2 📉 No Specify: black If Yes, Give Year or Dates: 1946 \$ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) manufacturing machinest Pages 1 and 2 should be filed v nent of Health and Mental Hygie snt: If Item 27 Is marked other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elenora -Duva11 John Duvall Sr ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Romaine Durant/daughter 3605 Hicks Avenue Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If It any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4X Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Due to (or as a consequence of): STAGE CARDIO MYOPATIL resulting in death) /Medical Examiner OROWHILY AR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner physician and s the burial-trans resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, pe Physician/Medical for use as signed by the attending be detached for use as IF FEMALE: yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has all director, page 2 s autopsy performe 1 ☐ Yes 2 🔽 No 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 DOTHER CONTROL 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? After 1 Natural
2 Accident 5 Pending investigation (Month, Day, Year) e Hospital or Attendil 124 hours after death. e Funeral Director: A death. 1 ☐ Yes 2 ☐ No in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To the I within 2 To the I 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number of death (Item 23a) (Type, Print) 30. Name and address of person who completed cause 5401 OLD COURTROAD Randallstown M Gborah

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year)

		1	For State	State of Maryland /	Department of Health and N Certificate of Death	Mental Hygien		12060			
	-		Registrar  1. Decedent's Name (First, Middle,	Last)	00711110010 07 200111	2. Date of Death	ay Year	3. Time of Death			
	° Physicia	an	Gleanora F	1. Dorsey.		Month Da	2009,	1:55 PM			
	/Medic Examin	_	4a. Facility Name (If not institution,	give street and number)	4b. City, Town, or Location of Death	4	c. County of Death				
4 4 g	Examin	100	REDGELOAS HALLOP	LIVESTAG - RE	H CATOUSTILE		BALTIL	LOPE			
Sign	Funeral			S. Sex 7. Age (In yrs. last I	Months Days Hours Min.	8. Date of Birth (Month, Day, Year	9. Birthr				
	Director		219-03-5895	66	Yrs.	11-20-192	ZILY	negivania			
	d 2 should be filed within 72 hours after death with the Maryland and Mental Hylene.  27 Is marked other than "natural", or Items 23s or 28s-1 show traumatic event, the Medical Examination ust be notified at	-	Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Location						
		to	MD BAL	TIMONE (	ALONSVILLE			1 Yes 2 No			
	r 28a	irec	10e. Street and Number		10f. Zip Code	10g. C	citizen of What Cou	ntry?			
	th wit	a D	5747 DV	nonvosar	7770		417,17	and feeting			
	r dea	Funeral Director	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- o Rican, etc.)					
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ② Widowed 4 ☐ Divorced	d 1 ☐ Yes 2 D No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: 431	acx			
21215-0036	72 hours after natural', or Ite	edt	15. Decedent's	Education 16	6a. Decedent's Usual Occupation		Kind of Business/Ir	ndustry			
215	within 7% ene. than "na	To Be Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed)  College (1-4or 5+)	(Give kind of work done during most of world life. DO NOT use retired)	King	HOME				
21	od wit		IOTA	NIA	VOMESTIC	- /Cina Asidata Asaida	1 WITH				
nd	be filed tal Hygli d other event,		17. Father's Name (First, Middle, L.	2- 0-1/0	18. Mothers Nat	me (First, Middle, Maide	an Sumame)				
Maryland	nould be I Mental narked on		19a, Informant's Name/Relationshi	TUDAS	9b. Mailing Address (Street and Number or Ri	ural Route Number, City	or Town, State, Zi	p Code)			
Mai	d 2 shoth and the modern of th		19a. Informant's Name/Relationshi	14/2/2/	2410 (1/M) VallE	1 Trus V	1 KESV1/5/	MD. 21298			
	1 an Heal em 2		20a. Method of Disposition	20b. Place	e of Disposition (Name of etery, crematory or other place)	Date 20c	Location - City or T	own, State			
Baltimore,	0 0 = 5		1 Burial 2 Cremation 4 Donation 5 Other (Sp.	3 Removal from State	+ -0 10	4-09 Na	MA169 1	11/15 MM			
Ħ	그 문 뿐 중		21. Signature/a Funeral Service L		22. Name and Address of Facility	NFragMil	TON JAH	21229			
m	Depared Important any in		Short (IM)	arel	GARY P. MARCH HUM	BRD/NOME	· VIA PO	DIMV,			
	•		23a, Pagn. In er the disease, or of shock, o heart failure. List of	complications that caused the death. It inly one cause on each line.	Do not enter the mode of dying, such as cardia	c or respiratory arrest,		Interval Between			
	Physician		Immediate Couse (Final disease of condition	a pretartate non	-snace ver Cosciloma	- Rightlong	,	T rentes			
1	/Medical Examiner		resulting in death)	Due to (or as a consequence of):  Due to (or as a consequence of):  C. Due to (or as a consequence of):							
		<u></u>	Sequentially list conditions if any, leading to immediate								
	ited insit	Examiner	cause. Enter Underlying Cause (Disease or injury								
ć	eath certificate be executed attending physician and for use as the burial-transit	Exa	that initiated events resulting in death) Last								
160	te be ysicia ne bur	Ical		d							
89	rtifica ng ph s as th	Med	IF FÉMALE:				22.5				
Вох	death certifica e attending ph od for use as th	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy	eath 3 Ectopic pregnancy		23d. Date of deli	very Day Year			
0.	9 o 5	Physiclan/Med	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at time of death 9□Unknown	n 5 Other (specify)						
Δ.	The law requires that the deatl ate has been signed by the atte bage 2 should be detached for	, Ph	Part II. Other significant conditio	ns contributing to death but not resultir	ng in the underlying cause given in Part I.	23e. Did tobaco	co use contribute to	Country of Death  Bally Find Scale or Foreign   Sountry			
Records,	uires thai signed t	Be Completed by	· Hopotenson			1 🗆 Yes	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Shknown				
CO	w requir		Desches			24a. Was an autopsy	24b. Were au	topsy findings available			
Re	The lav te has		Chamir Dechretic	a Poloonay Dream		performed	? death?				
Vital	ician: Th certificate ector, pag		25. Was case referred to medical		26. Place of De	eath Check onl one					
of V	Physician: this certific ral director,	To	examiner? 1 Tes 2 To		VOutpatient 3 DOA Other: 4 Nursing  Bb. Time of Injury at Work?	Home 5 Residence		cify)			
o L	ther men	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28d. Describe now i	njury occurred						
Sio	Attending r death. ector: After by the fune	Certification:	2 Accident investig	not be 380 Place of Injury . At home	8 290 Place of Injury - At home farm street factory office 28f. I			28f. Location (Street and Number or Rural Route Number, City or Town, State)			
Division	or Attendii after death. Director: A i in by the fu	ertif	4 Homicide determine	building, etc. (Specify)							
1	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifyin	g Physician: To the best of my knowle	Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause( xaminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date ar						
6	e Hoo	edical	(Check only 2 Medical one)	Examiner: On the basis of examination and manner stated.	n and/or investigation, in my opinion, death occ						
	To th Withir To th comp	M	29b. Signature and title of certifier		29c. License number		-	_			
	1		Marcal (ile	suce is	D19667						
20. Name and address from who completed cause of death (Item 23a) (Type, Print) Crucae   Riverses 730 Ritchie Highway # 508 Clou Birner, Maerland 200							1061				
	Ye.		31. Date filed (Month, Day, Year)	32. Registrar's Signatur	ree wy money son	the American Comments of the					
	St Regist	ate rar	OCT 0 7 200	32. Registrar's Signatur	park						

ian	State Registrar  1. Decedent's Name (First, Middle, L	ast)	Cer D	tificate of Death	2. Date of Month	Reg. No. Death Day	3. Time of Death	
ical ner	4a. Facility Name (If not institution, g  The Johns Hopkins I			Vans 4b. City, Town, or Location Baltimore City	n of Death	4c. County	of Death	
	5. Social Security Number  215-46-7049  Usual Residence of Decedent	Sex 7. Age 7. Ag	(In yrs. last birthday) 42 Yrs.	If Under 1 Year If Under Months Days Hours	Min. 8. Date of (Month,	8irth <i>Day,</i> Year) <b>8-1947</b>	Birthplace (State or Foreig Country)	
tor	10a. State 10b. County		10c. City, Town or Lo				10d. Inside City Limit	
al Director	10e. Street and Number 4600 Fair Vic	οω Δυθ.	<u></u>	10f. Zip-Code		10g. Citizen of W	hat Country?	
by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	<ol> <li>Was Decedent Ev Armed Forces?</li> </ol>	)	Was Decedent of Hispanic C If Yes, specify Cuban, Mexic 1 ☐ Yes 2 ☑ No Specif			- American Indian, k, White, etc.	
To Be Completed	15. Decedent's (Specify only highest of Elementary/Secondary (0-12)		(Give	dent's Usual Occupation kind of work done during m DO NOT use retired)		16b. Kind of Bu	siness/Industry	
	17. Father's Name (First, Middle, Las	<u>ns</u>		18. Mo	ther's Name (First, Mid Orogre+	Fairf	ay.	
	Padricia A. Eva	,	440	ng Address (Street and Num		.Himore, 1	ND 21216	
	20a. Method of Disposition  1 □ Gurial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe  21. Signature of Funeral Service Lice	cify)	20b. Place of Disponsion Commenter, cre. Woodler	matory or other place)		wordla c. Green	City or Town, State  Ly MD  Principal Sus  MD 21133	
	23a. Part 1. Ent i the disease, or co shock, or he ailure. List onl Immediate Cause (Final disease or condition resulting in death)		tatic Carconsequence of):				Approximate Interval 8etween Onset and Death	
Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Acute r Due to (or as a	consequence of:  Spiratory footsequence of:	ire	7			
Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1  Live birth 2 4  Pregnant at ti 9  Unknown	Fetal death 3	Ectopic pregnancy Other (specify)		23d. Dat	e of delivery nth Day Year	
by	Part II. Other significant conditions	No.	cco use contribute to the cause of death?					
Completed					24a. W au pr	utopsy erformed?	Were autopsy findings available or or to completion of cause of death?	
Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 1 Inpatient	t 2 🗆 ER/Outpatie	Other	ce of Death (Check on		er (Specify)	
ion: To	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day )	28b. Time of		28d. Descri	be how injury occur		
Certification:	2 Accident Investigat 3 Suicide 6 Could no 4 Homicide determine	reet, factory, office						
edical (	29a. Certifier (check only one)  1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.							
Med	29b. Signature and title of certifier	29c. License numbe		_	29d. Date signed (Month, Day, Year)  October 2, 2009			
	30. Name and address of person will	no(completed cause of de	ath (Item 23a) (Tyne	D-i-4)				
ate	ASNIEV Helgesov 31. Date filed (Month, Day, Year)				600 North V	Volfe St, Ba	Itimore, MD, 2128	

State of Maryland / Department of Health and Mental Hygiene

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2009 Chape Eregha Deborah 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 940Sedale Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, (In yrs. last birthday, Min 1 M X F Yrs 215-85-5854 03 10 59 Nigeria Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b, County 10a. State 1 ☐ Yes 2 No Baltimore Middle River MD 10g. Citizen of What Country? 10e. Street and Number Nigeria 21220 805 Northrop Lane 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 TNo Specify Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Unemployed Unemployed 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) C. I. Okundaye B. O. Okundaye 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 805 Northrop Lane, Middle River Md 21220 Onajite Eregha-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Memorial Park 10/7/09 Woodlawn, Md 22. Name and Address of Facility MarchF/H West 21. Signature of Funeral Service Licensee Md 21215 Baltimore, Wabash Ave, 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition wetas father Cancon Approximate Interval Between Onset and Death disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 2 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 □Yes 2 ŪNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 2 1 No

**Physician** /Medical Examiner

Pages 1

**Physician** 

/Medical

**Examiner** 

Director

Funeral

Completed

Be

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**Funeral** 

Director

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, Itw Medical Examinar must be notified at

burial-transit and attending physician for use as the buria cate has been signed by the page 2 should be detached this

P.O. Box 68760,

Division of Vital Records,

Examiner Physician/Medical 2 Completed

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After letely filled in by the funeral within 2 the

State Registrar

2

25. Was case referred medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 Vio 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Mann of Death 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29c. License number 29b. Signature and title of certifier ao

29d. Date signed (Month, Day, Year)

who completed cause of death (Item 23a) (Type, Print)

Mare Drive

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 _ State	/laryland		artment of He tificate of De			0011	0 22071
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	Physician/ Medical		October 5,2009							12:24P M
	Examiner		4a. Facility Name (if not institution, give street and number)  Stella Maris			4b. City, Town, or L	ocation of Death		4c. County of Dea	
	Funeral		5. Social Security Number 6. Sex 7. A	ge (In yrs. la			If I Inder 24 Hrs	8. Date of Birth	d Pi	rthplace (State or Foreign
	Director		218-42-2137 Usual Residence of Decedent	04	Yrs.			April 2	Year) 26,1945 Ma	ryland
	yland f shov ed at	tor	10a. State 10b. County	10c. City	, Town or Lo					10d. Inside City Limits
	e Mar r 28a- notifie	Direc	Md. Harford  10e. Street and Number	l		Jarretts  10f. Zip Code	VIIIe		10g. Citizen of What C	1 🗌 Yes 2 ื No
	with th	Funeral Director	1720 Trotting Court			21084			USA	ountry
e.	death items ner mu		11. Marital Status 12. Was Deceden			Vas Decedent of His	panic Origin? (Spec	ify Yes or No- ican, etc.)	14. Race - Am Black, Whi	
р•п 336	al", or	d by	1 Never Married 2 Married 1 Never Married 2 If Yes, Give Year or Dates.	No		☐ Yes 2X No			Specify: W	, , , , , , , , , , , , , , , , , , , ,
24 5-0	2 hours "natur dical l	plete	15. Decedent's Education (Specify only highest grade completed)	- 1	16a. Deced	lent's Usual Occupat	tion		16b. Kind of Business	s Industry
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9 ام 2	filed w al Hygi I other vent, t	Be	17. Father's Name (First, Middle, Last)			Ī	18. Mother's Name	(First, Middle, N	Maiden Surname)	-
2009 aryland	Menta	2	James R. Foltz				Nancy Mo			
5, , Mar	12 s lith a 27 i		19a. Informant's Name/Relationship (Type, Print)  Kathleen M. Foltz Sp	ouse		g Address (Street ar.  O Trottin			City or Town, State, Z	
OCTOBER Baltimore,	e 1 and t of He If item or othe		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		ace of Dispo	sition (Name of natory or other place,	) Da	ate	20c. Location - City of	r Town, State
OCTOBER Baltimore	it. Pag irtmen ortant: njury		4 Donation 5 Other (Specify)		aney V		10-9-2		Timonium, Funeral Ho	
OC Ba	Departing Important any is		21. Signature of Pureral Service Los nee		22		5 Belair		ttingham,	
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	Examiner			a conseque	ence oi).					
9	sit sd	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	s a consequ	ence of):					
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687	ertifica ding ph		IF FEMALE: 23c. If yes, outcom	e of pregnar	ncv					
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P.O. E	it the d I by the	Phys	g Unknown  Part II. Other significant conditions contributing to death		ulting in the u	ndorlying sauce alvo	n in Port I	District	pacco use contribute t	- the paying of death?
	Attending Physician: The law requires that the death certific sr death. extificate has been signed by the attending by the funeral director, page 2 should be detached for use as	ed by	Tattin Still Significant Continues to Still Stilling to Scient				arm arci.	1 🗆 Ye	,	Probably 4 Unknown
ROBERT FOLTZ of Vital Records,	To the Hospital or Attending Physician: The law require within 24 hours after death.  To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should	Completed						24a. Was ai	sy prior to	utopsy findings available completion of cause of
T F	n: The ficate l vr, page		25. Was case referred to medical			00 81-	ce of Death (Check of		med? death? 2▲ No 1 ☐ Ye	es 2 No
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	ling Ph TAfter th funeral		27. Manner of Death 1	ury ay, Year)	28b. Time of injury	28c. Injury a work?	at 28		w injury occurred	
Division	Attencer death	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of It	njury - At hor	me, farm, stre	M 1 ☐ Y	'es 2 □ No 2		reet and Number or Ri	ural Route Number,
Οį	oital or urs afte eral Dir illed in		building, etc. (Speciny)  City or Town, State)							
	ne Hosi n 24 ho ne Fune pleted i	Medical	29a. Certifier (Check only one)  1 ☐ Certifying Physician: To the best of 2 ☐ Medical Examiner: On the basis of 3 X Certifying Nurse Practioner: To the control of the con	examination	and/or invest	igation, in my opinion	, death occurred at the	ne time, date an	d place, and due to the	cause(s) and manner stated.
_	To t With To t		29b. Signature and theyof confifier	,		29c. License	number	2	9d. Date signed (Mon	th, Day, Year)
			30. Name and address of person who completed cause of	death (Item	23a) (Type, F	rint) K/99	172		10/5/20	07
1011						LEY RD.	TIMONIUM,	MD 21	093	
4	Stat Registra		31. Date filed (Month, Day, Year) 7 2009 32. Refis	rar's Signati	J. A	and				

FOWLER

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 9:20 October 2009 Rose M. Fowler /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Manor Care Ruxton Towson If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year)

Jan 21, 19 Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🔽 F 1921 184-16-1976 88 Pennsylvania **Director** Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10h. County of Heath and Mental Hygiene. I flem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2√∑ No Director MD Baltimore Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1707 White Oak Avenue 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: white ⋛ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) supermarket cashier 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Perry Patsy Fair 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1224 Charmuth Road Timonium, MD 21093 Connie Lew/friend 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Department of Important: If It any injury or conce. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) Signature of Euneral Service Licen Waster <sup>22. Name and Address of Facility</sup> State Anatomy Board 655 W. Baltimore Street irector 21201 Baltimore, MD Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line Immediate Tause (Final disease or condition resulting in death) year ance **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Due to for es a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical signed by the attending p IF FEMALE 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Year 5 Other (specify) □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b: Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗓 2 No 1 □Yes 26. Place Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4D Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 24 hours after death.

Funeral Director: After this letely filled in by the funeral dir Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manny of Death 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could pot be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 121 40 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death October 04, 2009 **Physician** Fischbach /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Frederick Villa Nursing & Rehab Baltimore Catonsville 8. Date of Birth 11-21-1921 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 1 □ M 2 🕱 F Pennsylvania 184-16-4858 87 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or 28a-f show event, the Medical Examiner must be notified at 1 □Yes 2 No Director Baltimore Halethorpe 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 1024 Downton Road United States or items 23a by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ∐Yes 2**X**XNo Specify: Specify: 3 Nidowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Executive Office Manager Dredging Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Beam Shepherd Rilla Mitchell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 Is
any injury or other trau Bruce H. Fischbach - son 1024 Downton Rd., Baltimore, Maryland 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 12 Burial 2 Cremation 3 Removal from State Meadowridge Mem Pk. 10-08-09 Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home, 21. Signature of Funeral Service Licenses 7250 Washington Blvd., Elkridge, MD. 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death cardiovancelas Immediate Cause (Final **Physician** 10 year disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of). Examiner resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ⊅no 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined

Hospital or Attending Physician; The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral

> 0 Registrar

4 Homicide

(Check only one)

29b. Signature and

29a. Certifier

Medical

29c License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Pelecul hours, 720 his den Chou but but, Hold 21228 32. Registrar's

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and majorer stated.

			For State Registrar	State of Maryla	nd / Depa	artment of rtificate of	Health ar f <i>Death</i>	nd Mer		iene 2	009	32074
	a Di		1. Decedent's Name (First, Middle, Last)						Date of Death Month	h Day	Year	3. Time of Death
	Physicia /Medic		LARRY JASPEI	R FOSTER					ctober		2009	8:50 p <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City, Town,	or Location of I	Death		4c. Cour	nty of Death	
and .			FUTURE CARE- SAND				LTIMORE				/A	100
	Funeral		5. Social Security Number 6. Sex	M 2 TE	s. last birthday)	If Under 1 Yea Months Day		Min.	Date of Birth (Month, Day,	Year)	Cou	place (State or Foreign ntry)
	Director		214-64-8263 Usual Residence of Decedent		56 Yrs.			A.	PR. 15	1953	MAF	RYLAND
	land	}	10a. State 10b. County	10c. C	ity, Town or Lo	cation					T	10d. Inside City Limits
	Mary fish	Ö	MARKE AND N/A			3.T. (III.) (III.)						XXYes 2 □ No
	the 28a	Directo	MARYLAND   N/A  10e. Street and Number		E	10f. Zip Code			10	0g. Citizen	of What Cou	ntry?
	3a or		2230 MADISON AV	ENUE		2	L217			II -	S.A.	
	ms 2	Funeral		2. Was Decedent Ever in I	J.S. 13.	Was Decedent of	f Hispanic Origin	in? (Specify	Yes or No-	14. F	lace - Ameri	
ထွ	after or ite		1 XXNever Married 2 ☐ Married	Armed Forces? 1	1	n res, specily Cu 1 □ Yes 2 <b>XX</b> N		ruerto nica	ari, etc.)		lack, White,	
1215-0036	i within 72 hours after death with the Maryland jiene. r then "natural", or items 23a or 28a-f show the Micdeal Examiner must be maillisd at	d by	3 Widowed 4 Divorced	Year or Dates:		10103 2011	о зресну.			Spe	cify: BLF	ACK
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2	within iene.	dm	Elementary/Secondary (0-12)	College (1-4or 5+)		DO NOT use reti	red)			D3.00	707.00	AMDUL ANGE
22	e filed vall Hygie other i	ပိ	12th grade  17. Father's Name (First, Middle, Last)		DR	IVER	18. Mother's	s Name (Fi	irst, Middle, N			AMBULANCE
au	d be fantal	Be c							H FOST			
Z	should nd Me mark matic	우	JASPER BROWN  19a. Informant's Name/Relationship (Typ	e Print)	19b. Maili	ng Address (Stre					vn. State. Zi	p Code)
<u>8</u>	nd 2 s ulth ar 27 ls r trau		Elizabeth Foster/M			Madison						
ē,	es 1 and 2 should be filed vor Health and Mental Hygis fitem 27 Is marked other ir other traumatic event, It		20a. Method of Disposition	20b.		osition (Name of matory or other p		Date		20c. Location		
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Baitimore, Maryland 21	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service License	_		2. Name and Add						
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			23 Fart 1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the dea	ath. Do not en	ter the mode of d	lying, such as ca	ardiac or re	espiratory arre	est,		Approximate Interval Between
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68/	ificate g phy: is the	edic	0.									
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m	death on aften	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o		☐ Ectopic pregna ☐ Other ( <i>sp</i> e <i>cify</i> )					Month	Day Year
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	law requires that the d as been signed by the 2 should be detached	by F	Part II. Other significant conditions conf	ributing to death but not re	esulting in the u	inderlying cause	given in Part I.					the cause of death?
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ပို	law ras be	ple							24a. Was a autops	sy	prior to c	topsy findings available ompletion of cause of
<u> </u>	: The l	Completed							perform 1 □ Yes	med? 2 No	death? 1 □ Yes	2 □No NA
Vital Records,	<b>Physician:</b> The lav rthis certificate has ral director, page 2.a	Be	25. Was case referred to medical examiner?	ospital:			)thor		Check only on			
0	di is	<u>1</u>	1 Yes 2 No	1 ☐ Inpatient 2	☐ ER/Outpatie	III 3 L DOA			5 Reside			eify)
	ing Affe une	tion	Natural 5 ☐ Pending	(Month, Day, Year)	Injury		njuryat /ork? □Yes 2 □ N		i. Describe no	ow injury oc	Janea	
Division	Attending er death. rector: After by the fune	fica	3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At	home, farm, st				Location (Si	treet and Nu	ımber or Ru	ral Route Number,
2	after Dire	Certification:	4 ☐ Homicide determined	building, etc. (Spec					City or Town	n, State)		
	e Hospital or Attend 124 hours after death e Funeral Director: /	1		ician: To the best of my k								
	To the Hospital or within 24 hours after To the Funeral Directory filled in the	edical	one)	er: On the basis of exami and manner stated.	manori ariu/of i							
	Vith Vith Com	Σ	29b. Signature and title of certifier	00	3017-320	29c. Lice	ense number らいいよる	2545	2	29d. Date sig	ned (Month	Day, Year)
				Primar.	,							
			30. Name and address of person who con		em 23a) (Type	Print)	suno.	74	a An T	mon	<i>[</i> Δ	21201
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Sig	mature		U - 3 41 C	711	1200		, , , ,	
	Registr		961 0 7 Z009	Denova &	. gar	Kind						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month; LTobel 10 40 a M Mary Agnes Gibbings 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Doctors Community Hospital Lanham If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Months Days Min. Hours 1 ☐ M 2 🛛 1914 95 May 1, Trinidad 073-50-1776 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10h County 1 Yes 2 □ No Prince George's Maryland Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 802 New Orchard Place 20774 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married 1 □Yes 2 No Specify. Specific Indian 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Morgan Adelaide (Unobtainable) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 New Orchard Pl., Upper Marlboro, MD 20774 Rosalind Roxborough (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State East Elfers Cemetery 10/10/09 Elfers, FL 4 Dorration 5 ☐ Other (Specify) 22. Name and Address of Facility
Thomas Dobies Funeral Home
8825 Old County Rd. 54 New Port Richey, FL 34653 21. Signature o Funeral Service Livense lmece 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pneumonia Due to (or as a consequence of). Chronic Obstructive Airway Disease Directo (or as a consequence of) Due to (or as a consequence of): yes, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Day 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

r 28a-f shov

Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or amy injury or other traumatic event, the Medical Evaniner must be once. Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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the Maryland

Examiner physician and the burial-transit Physician/Medical use as for cate has been signed by the page 2 should be detached in 2 Completed funeral director. Be Certification: To ours after death.

**To the Hospital or Attending Physician**: The law requires that the death certificate be executed

certificate has

After this

O. Box 68760.

σ.

Division of Vital Records,

disease or condition resulting in death) Sequentially list conditions, if a y, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 💆 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Dementia autopsy performed 1 ☐Yes 2 🗓 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nation 2 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpati 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 29a. Certifier

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

within 24 hours a To the Funeral L completely

Medical

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7525 Greenway Ct. Drive, Greenbelt, MD

D23743

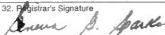
1 ☐Yes 2 ☐ No

October 4, 2009

State Registrar

31. Date filed (Month, Day, Year) OCT 0

Martin Weltz, M.D.



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year 4:00 AM **Physician** 10 03 2009 JENNA ELYNN GANS /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTMOREIMD UNIU, OF MALYCAND MEDICAL CTA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | 5/30/1997 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1 □ M 2 🕱 F MARYLAND 218-49-7539 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Wedical Examinational be notified at 1 ☐Yes 2 ☑ No Funeral Director TOWSON BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 4 AINTREE ROAD 21286 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 □XNo Specify Specify: WHITE Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STUDENT N/A 5TH GRADE Departmen<sup>®</sup> of Health and Mental Hygie Important: If item 27 is marked other t any injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fill and Mental F JOLENE E. BOYCE DANA R. GANS ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) DANA R. GANS/FATHER 4 AINTREE ROAD TOWSON, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Pages 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State DULANEY VALLEY MEM. 4 ☐ Donation 5 ☐ Other (Specify) 10/8/2009 | COCKEYSVILLE, MD GARDENS and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21. Signature of Funeral Service Licensee MOQ247 21286 TOWSON, MD 8521 LOCH RAVEN BLVD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final **Physician** ENTEROBACTER SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CUNCORUINAL HEART DISEASE OMPLEX CHALORE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as attending plant for use as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 4 Pregnant at time of death 5 Other (specify) P.0. cate has been signed by the page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 **N**o 3 Probably 4 Unknown PLOTEIN - LOSING ENTELOPATHY 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an SEVELE HYPOXEMIA autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 ☑No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at 27. Manner of Death 1 Natural 5 Pending al or Attendir s after death. I Director: At 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated.

3

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

OF MD MIDICAL CNL. 22 S. GLEPLY ST DALL MILL, M.D. UNIU. 32. Registrar's Si

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D0069696

29d. Date signed (Month, Day, Year)

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician**  $\omega$ :0 Octobes FLOYD **GARNER** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examine Point Loolvood AV 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Days Min. Months Hours SC MARCH 17,1923 86 250-12-1504 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinat must be notified at 1XYes 2 ☐ No Director BALTIMORE MD Known Te Mysician; Garner, Floye altimore, Maryland 21215-0036 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21216 2906 BRIGHTON ST. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XXYes 2 □ No If Yes, Give Year or Dates: WWII Race - American Indian, Black, White, etc. 11 Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No Specify. Specify. þ BLACK 3 ☐ Widowed 4 ☐ privorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) marked other than Elementary/Secondary (0-12) BETHLEHEM STEEL LABORER 9 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othany injury or other traumatic event 17. Father's Name (First, Middle, Last) Be ADDIE SPRINGS WILLIAM GARNER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6818 YATARUBA DR. BALTIMORE, MD 21207 ADDIE GARNER/NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 😿 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21229 10-7-2009 BALTIMORE, MD METRO CREMATORY 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC. 21. Signature of Funeral Service Licensee 1701-31 LAURENS ST. BALTIMORE, MD Approximate Interval Between Onset and Death 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Smouths Dementia **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. attending physician Physician/Medical as the nse ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day for in the past 12 months? 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ficate has been się r, page 2 should b Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director, Other: Hospital: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death After (Month, Day, Year) Injury 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. after death

Director: / 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 124 hours after le Funeral Dire pletely filled in b Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier within 24 ho

To the Fune

completely (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

J \ √ | State

State Registrar Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar' Signat

Giminaro,

HO054439

VA Maryland Healthcare System Perry Powe, MD

Ochber 5, 2009

			1 - State Registrar			Certificate of	Death	R	eg. No.	19 22678
	Physici /Medic		1. Decedent's Name (First, Mid LAW RENC	. ,		HOLT2	,	2. Date of Deat Month	Day	Year 3. Time of Death
· Ohne	Examir		4a. Facility Name (If not instituti	on, give street and number	7) 0	4b. City, Town, o	or Location of Deat		4c. County o	
4			BALTIMORE WASH	INGTON MEDICA	L CENTE	a GLE	n Bukn	IE	ANNE	ARUNDEL
	Funeral Director		5. Social Security Number 235.36.1128	6. Sex 1☐ M 2☐ F	ge (In yrs. last bir 82	thday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, OCT 20, 1	Year)	Bithplace (State or Foreign Country)  WV
	pr ,		Usual Residence of Decedent							
	arylaı Show	-	10a. State 10b. Count	У	10c. City, Town	or Location				10d. Inside City Limits
	8a-f	Director		ARUNDEL	GLEN B					1 □ Yes 2 □ No
	vith th	ä	10e. Street and Number			10f. Zip Code		1	0g. Citizen of Wi	hat Country?
	s 23a	erai	210 KENT RD.	1		2106			USA	
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Evanter court by mylfind at	d by Funeral	11. Marital Status  1 Never Married 2 Marital  3 Widowed 4 Divorce		? ] No	13. Was Decedent of I If Yes, specify Cub 1 □Yes 213 No		pecify Yes or No- o Rican, etc.)		- American Indian, , White, etc.
5-	72 h 'natu	ete	15. Decede (Specify only high	ent's Education lest grade completed)	16a.	Decedent's Usual Occu (Give kind of work done	during most of wor	king	16b. Kind of Bus	siness/Industry
121	within iene. than "	Completed	Elementary/Secondary (0-12)			life. DO NOT use retire	ed)			(EDAN IE) IT
121	filed v Hygie yther t		17. Father's Name (First, Middle	\ / aat)		PIPE FITTER	40. Mathada Nam	/Eirot Middle A	U.S. CO	
anc	Mental Harked ot	Be						ne (First, Middle, I	vialueri Surriame	"
Maryland	should and Mer s marke umatic	မ	JAMES BISMARK H		100	NA-11- A 14 (O4	STELLA E		0:	2-1- 7-0-1-
Ma	nd 2 sho alth and 27 is ma		19a. Informant's Name/Relation			. Mailing Address (Street			r, City or Town, S	state, Zip Code)
	1 and 2 Health tem 27 is		CARMELA KATHER II	NE HULIZ	-	DISPOSITION (Name of	N BURNIE, M		20c. Location - 0	City or Town, State
Ō	Pages nent of int: If its		1 KBurial 2 ☐ Cremation		cemeter	y, crematory or other pla				
Baltimore,	artme ortan injun		4 □ Donation 5 □ Other (		GLEN HA	VEN CEMETERY	10.7.	2009	GLEN BURN	IE, MU
Ba	permit. Pages Department of Important: If it any Injury or once.		K CRECORY FX	hank	M01148	FINK FUNERAL 426 CRAIN HW		HDMLE MD	21061	
	Certificate be executed Character and Character as the burial-transit	cal Examiner	23a. Part Enter he die e se, shoo or he t faill ret Lis Immediate vuse (Final disease or c. r. iltion resulting in dea)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or a	ad the death. Do i line.  S 1 S s a consequence of the consequence of	on: 1715 on: ENAL	FATL		est,	Approximate Interval Between Onset and Death 2 DAY 2
		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		e of pregnancy 2  Fetal death at time of death	3 ☐ Ectopic pregnand 5 ☐ Other <i>(specify)</i> _	су		23d. Date Mon	of delivery th Day Year
Т,	s that ned t		Part II. Other significant condi-	tions contributing to death	but not resulting in	the underlying cause given	ven in Part I.	23e. Did tol	bacco use contri	bute to the cause of death?
rd.	quire; n sig and be	Q P	CHRONIC KI	DNEY DIS	EASE,	CHF-EF:	15%	1 □ Ye	s 2 No	3 ▼ Probably 4 □ Unknown
of Vital Records,	To the Hospital or Attending Physician: The law requires that the death within 24 hours after death within 124 hours after death. To the Euneral Director: After this certificate has been signed by the atter completely filled in by the funeral director, page 2 should be detached for u	Completed by	AFIB, VTACE	15/PAICD.	COPD	, HTN		24a. Was a autops perforr 1 □ Yes	nedy! de	/ere autopsy findings available rior to completion of cause of eath?  ☐ Yes 2 ☐ No
/ita	clan sertific	Be	25. Was case referred to medic examiner?		W.			th (Check only on	e)	
of \	Physic this cal dire	ဥ	1 ☐ Yes 2 🕅 No	7		tpatient 3 DOA Oth	4 LJ Nursing H	lome 5 Reside		
E C	Ing I	ö	27. Manner of Death 1 Natural 5 ☐ Pend	ing 28a. Date of In	lury 28b. 1 ay, Year) 28b. 1	ime of 28c. Injury Wor		28d. Describe ho	ow injury occurre	d
Division	or Attend ter death irector: n by the f	Certification:	3 ☐ Suicide 6 ☐ Could	inot be mined 28e. Place of Ir building, e	jury - At home, fa	M 1 C	]Yes 2□No	28f. Location (St City or Town	treet and Numbe n, State)	r or Rural Route Number,
	Hospital ( 24 hours ar Funeral D	Medical Cel	29a. Certifier 1 Certify (Check only one)	ing Physician: To the bes	of examination an	e, death occurred at the t	ime, date and place opinion, death occu	e, and due to the c arred at the time, d	ause(s) and mar late and place, a	nner as stated. nd due to the cause(s)
	o the vithin o the omple	Mec	29b. Signature and title of certifi	and manner s	iaieu.	29c. Licens	se number	2	9d. Date signed	(Month, Day, Year)
	F ≯ F 8		Janah				65095			ER 3,2009
	5		30. Name and address of perso	n who completed cause of	death (Item 23a)	Type, Print)			4	

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

HOLTZ, LAWRENCE

32. Registrar's Signature

JANAKI DEEPAK, BALTIMORE WASHINGTON MEDICAL CENTER, GLEN BURNIE, HID 21061

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 **Physician** Bernard Hawkins Sept. 30, 5:30a <sup>™</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Holy Cross Hospital Montgomery Co. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 212-42-9397 02-06-1944 Baltimore, MD Director 65 Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10c. City, Town or Location 28a-f show if than "natural", or items 23a or 28a-f shorthway to Mode and Evander at the motified at 1X Yes 2 □ No Director DC Washington 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 4425 14th Street, NW #58 20011 U.S.A. Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Armed Forces:

1 XYes 2 □ No
If Yes, Give
Year or Dates: 1961-1965 filed within 72 hours after 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Engineer Double Tree Hotel Department of Health and Mental Hyg Important: If Item 27 is marked other any Injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be George Conley Helen Hawkins 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Norma Hawkins - Wife 4425 14th Street, NW #58 Washington, DC 20011 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 10-9-09 | Silver Spring, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ronald Taylor II Funeral Home 21. Signature of Funeral Service Licenses Konol 10583 Middleport Lane, White Plains, Md. 20695 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Metastatic Lung Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Liver Failure Sequentially list conditions Examiner Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events law requires that the death certificate be executed burial-transit Colon Cancer resulting in death) Last Due to (or as a consequence of) Box 68760, physician the burial Physician/Medical attending pl IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Live birth 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) P.O. cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? After this certificate funeral director, page 1 ☐Yes 2 ☐No Division of Vital tal or Attending Physician: Tis after death. al Director: After this certificate bed in by the funeral director, pa 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No 1 Nnpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide determined To the Hospital within 24 hours a To the Funeral L Hospital 29a. Certifier 1 Control of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2101 Medical Park Dr., #201 Silver Spring, MD

DHMH 17 Rev 1/2001

State Registrar @

31. Date filed (Month, Dav. Year)

32. Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1 - For State Registrar			Cei	rtificate of	Death		eg. No. 🔠 📋	9 320	18
Physician		me (First, Middle, Las	t)				2. Date of Dear Month	Day Ye	1	
/Medical		J. Holland  (If not institution, give	etmat and number)		4h City Town o	r Location of Deatl		er 29, 20		_PM
Examiner			Medicaí Cen	ter	Chever				George's	
Funeral		Numbelunk 6. Se	7. Age (In )	rs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day		Birthplace (State of Country)	
Director			XM 2□ F 52	Yrs.	Months Days	Tiodio IVIIII	Aug 26			
3	Usual Residence 10a. State	of Decedent 10b. County	10c.	City, Town or Lo	cation				10d. Inside Cit	ty Lin
f sho ed at				Washir	oton				1 □Yes	2 X
or 28a-f sh be notified.	10e. Street and N	Number		Wasiili	10f. Zip Code		1	0g. Citizen of What	t Country?	
3a or		enilworth .	Avenue NE		200	019		USA		
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. At them 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at or other traumatic event, the Medical Examiner must be notified at To Be Completed by Funeral Director	3 ☐ Widowed	s unk arried 2□ Married I 4□ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba 1 □Yes 2X No	lispanic Origin? (S an, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)		American Indian, Vhite, etc. black	
ed within 72 houygiene. Ser than "natura t, the Medical E	(Sp Elementary/Se unk	15. Decedent's Ed pecify only highest gradecondary (0-12)	ucation de completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wor d)	un king	16b. Kind of Busine	ess/Industry	u
2 should be flied within and Mental Hygiene. is marked other than aumatic event, the IM.  To Be Comp		ne (First, Middle, Last)			unk	18. Mother's Nar	ne (First, Middle,	Maiden Surname)		ur
Mental H Mental H arked ott artic even										
should land Men and Men umarke umartic		Name/Relationship (7	Type. Print)	19b. Maili	ng Address (Street	and Number or R	ural Route Numbe	r, City or Town, Sta	te, Zip Code)	
1 and 2 Health a em 27 is other tra	Prince	George's 1	Medical Ctr		Hospita:					
Par He Par Line	4 ☐ Donation	2 ☐ Cremation 3 ☐ n 5 █ Other (Specify	in state		osition (Name of matory or other place	1	Date	20c. Location - City		
permit. Pag Department Important: I any injury o once.	- An	20//10	Direct	В	altimore.	MD 212	01	Baltimor	Approximate Interval Bet	
hysician   Medical	disease or cond resulting in deat  Sequentially list if any, leading to cause. Enter Un Cause (Disease that initiated ever resulting in deati	conditions, immediate denying or injury	b. Due to (or as a conduction of the conduction	rdro	coa	e us	office	) rey	day	S
	IF FEMALE:	Court arragment	d23c. If yes, outcome of pr		le 5	lun	obje	23d. Date of	of delivery	ı
at the death cert d by the attending etached for use a Physician/M	23b. Was deced in the past 1 Tes 9 Unkno	12 months? 2 ☐ No	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown		☐ Ectopic pregnan	су		Month	•	Yea
es the igne be d	Part II. Other sig	nificant conditions o	ontributing to death but not	resulting in the u	inderlying cause gl	ven in Part I.		obacco use contribu	_	
law relas be		Ha	Mone	ove	il.		24a. Was autop	sy prio	re autopsy findings or to completion of c	ava
The page		de	en reer	· The	combox	es	perfo 1 ☐ Yes		ith? ]Yes	
yslcian is certifi director,	25. Was case re examiner?	eferred to medical		2 ER/Outpatie	SIL SIL DOA	her: 4 \( \sum \) Nursing		dence 6 ☐Other	(Specify)	
After funera	27. Manner of D	5 Pending	28a. Date of Injury (Month, Day, Yea	28b. Time ( Injury	Wo	rry at rk? ]Yes 2. □No	280. Describe i	now injury occurred		
To the Hospital or Attending Phys within 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral director.  Medical Certification: To	2 ☐ Acciden 3 ☐ Suicide 4 ☐ Homicid	6 ☐ Could not be	e 28e Place of Injury	At home, farm, st becify)		1100 20110	28f. Location (: City or Tox	Street and Number vn, State)	or Rural Route Nur	nbei
ithin 24 hours of the Funeral ompletely filled		1 → ertifying Ph 2  Medical Exar	nysiclan: To the best of my niner: On the basis of exa and manner stated.	knowledge, dea mination and/or i	th occurred at the nvestigation, in my	time, date and pla- opinion, death occ	ce, and due to the curred at the time,	date and place, and	d due to the cause(	(s)
To the virthing community of the transfer of t	29b. Signature	and title of certifier	A- Celas	ies l	ND 29c. Licen	453 4	J	Septem	her-29	.2
	, 4	100-	11 0 00	,						
	30. Name and	ddress of person who	completed cause of death  ALFOS  32/Registrar's S	Pr	Print)	Georg	e H	spetal	Cheve	21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registrar Certificate of Death Rea. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death October 01, 2009 William Henning, Jr. 3:40 PM 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Tate Hospice 817 Camp Meade Road Linthicum
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year, 10/11/1930 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) Country) Virginia Months Days Hours Min. 1 → M 2 ☐ F 78 212-26-2076 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 No Maryland Baltimore Lansdowne 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 2402 Smith Ave. 21227 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1954-57 Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administration State of Maryland 4 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Jestus Henning, Sr. Zelma Gay Gall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Lois Henning/ Wife 2402 Smith Ave., Lansdowne, Maryland, 21227 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 10/5/2009 Elkridge, MAryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home 21. Signature of Funeral Service Licenses O 7250 Washington Blvd., Elkridge, Maryland 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final month disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify)

the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician and mpletely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Director

Funeral

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Completed

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Examiner

ician/Medical

**Examiner** 

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Workel Econnius is not be notified at once.

**Physician** 

/Medical

Examiner

Baltimore, Maryland 21215-0036

9 🗆 Unknown		9 Unknown				
Part II. Other signific	cant conditions o	contributing to death but not res	ulting in the underlying	cause given in Part I.		use contribute to the cause of death?
					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ▼ No
25. Was case referre	ed to medical			26. Place of De	eath (Check only one)	
examiner?	No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 Residence	6 Dother (Specify) Spre Hou
27. Manner of Death 1  Natural 2  Accident	5 Pending investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	ry occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		ome, farm, street, factory)	ory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number, 3)
		nysician: To the best of my kno niner: On the basis of examina and manner stated.				s) and manner as stated. d place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

0

within 2.

State Registrar

Year)

29b. Signature and title of certifier

31. Date filed (Month, Day,

09-07653 Charles Hollowa
Physicia Medical Exami

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Reg. No Registrar Time of Death 2. Date of Death 1. Decedent's Name (First, Middle,Last Month Day October 1, 2009 2016 hrs harles Holloway ıer 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Raltimore Bon Secours Hospital If Under 24Hrs. g. Birthplace (State or 8. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** 63 Director 194 424-54 -936 Country) Habama 1 M 2 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 No 28a-f show Maryland must be notified at once, death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 5. 16 athenn 14 Race - American Indian, Black, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. White, etc If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? Married Never Married 1 Yes Pages 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", o If Yes, Give Year Yes 2 No specify Specify 3 Widowed Divorced Examiner è 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) ted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Complet Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical. Baltimore, MD 21215-0036 Consultan 18.Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Yimie Fleming Hollowal Samue æ 19b. Mailing Address (Street and Number or Rural Route by 🍗 , City or Town, State, Zip Code) 21 19a. Informant's Name/Relationship (Type, rint) Catherine Battimore Ruthie tolloway 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 2 Burial Removal from State Maryland Cremation 0-3-09 Cremator Metro Donation 5 Other Specify. 21. Signature of Funeral Service License win Marylan 3512 Frederic Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. Medical a. Hypertensive cardiovascular disease complicated by Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): cocaine intoxication Sequentially list conditions, Due to (or as a cunsequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical 23a,27,28a-f,permE, g896 10/26/09 TT XUNPENDED attending physician a AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year Day 3 Ectopic pregnancy Month Fetal death past 12 months? Pregnant at time of death Other (Specify) 5 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. ò 1 Yes 2 V No 3 Probably 4 Unknown Completed After this certificate has been a funeral director, page 2 should 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of death? performed' ✓ Yes 2 ✓ Yes No 26.Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Division of Vital Be Other<sub>4</sub> Hospital: 1 Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA 1 V Yes 2 No Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Natural Yes 2 X No Pending Director: . Fd 7:40 pm 24 hours after death. Fd 10/1/09 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 16 S. Catherine St Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide To the Funeral I determined found at home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 2, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Donna M. Vincenti, MD 31. Date filed (Month, Day, Year) Registrar ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 **Physician** 11:39 AM MARGARET HOLCOMB OctoBer AGATHA 2009 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore N/A HARDOR Hos Di Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** may 8, 213-14-0653 Months Days Hours Min. 1 M 2 K F 89 1920 MD Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a "hedical Examinat is set be nutified at once. 10a. State MD N/A 1 ☐ Yes 2 ☐ No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country's 1449 Andre Street 21230 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 🔼 No Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White 2 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Nicholas Burg Elizabeth Tyson ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1449 Andre Street, Baltimore MD 21230 Anna Jane Burg / Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
Glen Haven Cemetery 20c. Location - City or Town, State 20a. Method of Disposition ¥XXBurial 2 ☐ Cremation 3 ☐ Removal from State 10/08.2009 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) License ictor P. Doda, Jr<sup>22</sup>. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 E. Fort Avenue, Baltimore MD 21230 21. Signature of Funeral 23a. Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Sepsis **Physician** days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ icate has been signated by page 2 should b 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy To the Hospital or Attending Physician: The certificate 2 No 1 Tyes 2 No 25. Was case referred to medical director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 1 MInpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this After thi funeral of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Cirector A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES DOO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) South HANOVER Street, BALTIMORE, MD 21225 George 3001

State Registrar 31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last)
Lee A. Henry 2. Date of Death Time of Death Physician/ Month Day Year September 26, 2009 Henry 1725 hrs Medical Examiner 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) 3404 Homeland Terrace Olnev Montgomery 5. Social Security Number If Under 1 Year | If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) Months Days Hours Min. 266-13-7367 Director 52 12/2/1956 FL1 X M 2 F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County MD 1 Yes 2XX No Montgomery 28a-f show Olney notified at once. Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 3404 Homeland Terrace 20832 USA items 23a or Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death wi
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items;
injury or other tranmatic event, the Medical Examiner must be. Armed Forces? Unk. XX Married White, etc. 1 Never Married Yes No Black If Yes, Give Year Yes 2 X No specify: Specify: Widowed Divorced 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Laborer Construction 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last)
Willie L. L. Henry Lorene Peterson æ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) Tracy Hall / Sister 10630 Lovette Drive, Fredericksburg VA 22407 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition 1 Burial 2 Cremation 3 K Removal from State Graceland Comm. Cem 10/10/2009 Graceville, Fl Donation 5 Other Specify:

Signature of Funeral Service Licensegictor P. Doda, Jr 22. Name and Address of Facility

Charles L. Stevens Funeral Home, I

1501 E. Fort Ave., Baltimore MD 21 Donation 5 Other Specify 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician failure. List only one cause on each line. Between Onset and /Medical Death Atherosclerotic cardivoascualr disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the attending physician and ed for use as the burial - transit To the Hospinal or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Physician/Medical AMENDED 23a,27, perME, g896 10/22/09 TT X UNPENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Day Year 2 Fetal death detached for use as past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 ✔ Unknown Completed certificate has been page 2 should 24b. Were autopsy findings available 24a, Was an autopsy prior to completion of cause of performed' death? No Yes 2 24 hou s after ceath.

Funer 4 Director: After this certificately fil ed in by the funeral director, 25. Was case referred to medical 26 Place of Death (Check only one) Division of Vital Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 ဥ 1 V Yes No 28c. Injury at Work? 28a. Date of Injury (Month, Day,Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification X<sub>Natural</sub> 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated 29b Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) September 27, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. State Registrar

			For State Registrar	State of Mary		artment of He rtificate of De			Reg. No.	10.15	32085
	Discontint		1. Decedent's Name (First, Middle, Last)					<ol><li>Date of Dea Month</li></ol>	ath Day	Year	3. Time of Death
	Physicia /Medic		WELDON J.	HARRISON				10	03		16:30M
and the same	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or Lo			4c. 0	County of Death	
1			GOOD SAMARITI	an Hosp	THAL	ISALTI				N/A	
	Funeral		5. Social Security Number 6. Sex	7.Age (In MM 2□F	yrs. last birthday)			8. Date of Birt (Month, Da		Cour	
н	Director		215-58-1869	HVI Z	57 Yrs.			MAR 8_	1952	MARY	LAND
	w		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Lo	cation				1	0d. Inside City Limits
	lanyla sho	ō									1 XYes 2 No
	the N 28a-1 lotifi	Director	MARYLAND N/A  10e. Street and Number		В	ALTIMORE 10f. Zip Code			10a. Citiz	en of What Cour	ntry?
	a or	Ö							-	J.S.A.	
	eath	Funeral	5620 GERLAND A	VENUE 12. Was Decedent Ever	in U.S. 13.	21206 Was Decedent of Hist	panic Origin? (Spe	cify Yes or No		4. Race - Americ	 can Indian,
	iter d	ᆵ	11. Marital Status 1 ☐ Never Married 2XXMarried	Armed Forces? 1 ☐ Yes 2 X X o		Was Decedent of Hisp If Yes, specify Cuban,	Mexican, Puerto I	Ricán, etc.)		Black, White,	etc.
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show after Examiner must be notified at	ģ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1∐Yes 2 <b>XXX</b> No	Specify:			Specify: BLA	CK
ŏ	72 hours "natural", oleal En	ed Ed	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupati	ion		16b. Kin	nd of Business/Inc	dustry
215	- 1 M	Completed	(Specify only highest grade Elementary/Secondary (0-12)	completed) College (1-4or 5+)	(Give	kind of work done dui DO NOT use retired)	ring most of workir	ng			
21	d withi giene. er than	ĕ	12th grade		ELEC	TRICAL SUI	PERVISOR		KIT	CHEN SUP	PLIES
þ	al Hygi other vent,	Be	17. Father's Name (First, Middle, Last)			1	8. Mother's Name	(First, Middle,	, Maiden S	Surname)	
<u> a</u>	uld be Vental rrked c	၉	JOHN T. HARRIS	ON			LELIA C	OHNSON			
ar)	2 should be finand Mental I is marked of raumatic eve		19a. Informant's Name/Relationship (Ty	pe. Print)	19b. Mailii	ng Address (Street an	d Number or Rura	l Route Numb	er, City or	r Town, State, Zip	Code)
Σ	<b>音 2 ま</b>		Shirl Harrison/Wi			Gerland Av					
or C	ges 1 a nt of Hear if item		20a. Method of Disposition  1 → Burial 2 → Cremation 3 → F	tomoval from State	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	į D	ate	20c. Lo	cation - City or To	wn, State
Ē	Pages ment of I ant: If ite ury or o		4 □ Donation 5 □ Other (Specify)	lemoval from State	WOODLAWN	CEMETERY	10-09	9-09	MOO	DLAWN,MA	RYLAND
Baltimore, Maryland	permit. Pages Department o Important: If i any injury or once.	10	21. Sign are of Funderal Service License	(_	WI	2. Name and Address LLIAM C BI 206 W NOR	ROWN COM		FUNE	RAL HOME	P.A.
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	Dharaisian	i yy	shock, or heart failure. List of nly or Immediate Cause (Final	ne cause on each line.						OMA	Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	Due to (or as a co	unsequence of).	2 50117	7272	CHE		701110	
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	cuted id ansit	Examiner	if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	e exectant and	Ä	resulting in death) Last	Due to (or as a co	ensequence of):						
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			IF FEMALE:								-
Вох	eath certific attending p for use as i	an/	23b. Was decedent pregnant	3c. If yes, outcome of p 1 ☐ Live birth 2 ☐		☐ Ectopic pregnancy			2	23d. Date of deliv Month	very Day Year
O.E	Physician: The law requires that the death certli r this certificate has been signed by the attending ral director, page 2 should be detached for use a	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at tim 9 ☐ Unknown	ne of death 5	Other (specify)				WORTH	bay roan
Ρ.	uires that the de signed by the a d be detached f	Phy	9 Unknown		the second second		in Don't I	230 Did	tobaccou	ise contribute to t	the cause of death?
	es th	þ	Part II. Other significant conditions con		or resulting in the o	indenying cause given	III Fait i.			□ No 3 □ Pro	
oro	w requir been s should	Completed	11050101017						103 -	1	
ec	e 2 sh	ple						24a. Was	psy	prior to co	opsy findings available ompletion of cause of
=	ate ha	S						1 □ Yes	ormed? 2 Z No	death? 1 □ Yes	2 🗆 No
/ite	iclan: The certificate ector, pag	Be	25. Was case referred to medical examiner?	In a shall			26. Place of Death	(Check only	one)		
£	hysi this c	ျ	1 162 5 140		2 ER/Outpatie		4 LI Nursing Ho			6 ☐ Other (Speci	fy)
ū	ng ffe	ü	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Ye	ear) 28b. Time o	Work?		28d. Describe	now injur	y occurred	
sio	Attending it death. ector: Afte by the fune	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	OC - Disea of Injury	At hame form of		es 2 No	29f Location	(Street on	d Number or Rus	ral Route Number,
Division of Vital Records,	after of after of Direct of in by	Certification:	4 ☐ Homicide determined	28e. Place of Injury building, etc. (\$	Specify)	reet, lactory, office		City or To			arribate (varibor,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ल	(O) 1 1 0 1 1 1 1	sician: To the best of miner: On the basis of ex and manner stated	manalana di manana ana al / mu il	acceptionation in maccani	mian dende annum	rad at the time	data and	dub back and due t	to the cause(s)
,	Vithin To the	Me	29b. Signature and title of certifier			29c. License	number		29d. Dat	te signed (Month	, Day, Year)
	. 2 - 0		> grown,	M.D		UMPS	5 239	86	10	0-05-	-2009
			29b. Signature and title of certifier  29b. Signature and title of certifier  30. Name and address of person who compared to the compared to t	ompleted cause of death	maritant	Print)	5601 Lo	oh faver	BI	id , Balt	there MD2123
	Sta	ite	31. Date filed (Month, Day, Year)	82. Registrar's	Sign ture	Ked					
	Regist	rar	UCT 0 7 2009	Alexan	10. 19 W	W					
DL	MH 17 Rev 1/2	001									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State	Stat	e of Mar		-	ment of F icate of D	lealth and N	/lental Hy		0.0	3500:
			Registrar  1. Decedent's Name (First, M.	iddle, Last)			Cerui	cate of L	Jean .	2. Date of De	Reg. No.	1110	3. Time of Death
Н	Physicia Medic		Garland Way	ne Houck						Month 10	8 <sub>2</sub>	2009	
-	Examin		4a. Facility Name (if not institu		i number)		41:		Location of Death		4c. Co	ounty of Death	1
		Н	315 Union St 5. Social Security Number	6. Sex	7 450 (	In row look hintle	eday) If	Aberde	en If Under 24 Hrs.	Lo Data d Bio		ford	
	Funeral Director		212 48 8671	1 🔀 M 2 🗆	F 7. Age (	In yrs. last birth		onths Days	Hours Min.	8, Date of Bir (Month, Da 03-08-		Gou	hplace (State or Foreign Intry) Maryland
	and show	ō	Usual Residence of Deceden 10a. State 10b. Co		1	0c. City, Town	or Location	on					10d. Inside City Limits
	Maryla 28a-f ptified	irect	Maryland Ha:	rford		Aberde	en						1 🔀 Yes 2 🗌 No
	3a or	al D	10e. Street and Number		•		1	0f. Zip Code			-	n of What Co	untry?
	ath wii	Funeral Director	315 Union St		Decedent Eve	er in IIS	13 Was	21001	spanic Origin? (Spe	ocify Yes or No-	U.S.A		ione Indian
9800	1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Married 2 3 Widowed 4 X Divo	Married Arme	d Forces? Yes 2 🛛 No., Give or Dates.		If Yes	yes 2 No	n, Mexican, Puerto	Rican, etc.)		. Race - Amer Black, White ecify: Whi	, etc.
Maryland 21215-0036	thin 72 hou sne. than "natu se Medica	Completed	(Specify only I	edent's Education highest grade comple (2) Collection	eted) ge (1-4 or 5+)		(Give kind life. DO N	OT use retired)	luring most of worki			of Business I	
d 2	filed wii al Hygie d other event, th	Be C	17. Father's Name (First, Mide	lle, Last)		. IHea	vy E	<u>uipmen</u>	t Operato 18. Mother's Name			struct:	1011
/lan	should be filed within and Mental Hygiene. is marked other tha aumatic event, the I	욘	Albert Cleve	land Houck	ς				Anna Mae			,	
	and 2 should Health and Me em 27 is mar ther traumati		19a. Informant's Name/Relat Michelle Pres		ıghter		_		and Number or Rura Aberdeen		-	wn, State, Zip	Code)
Baltimore,	- 0		20a. Method of Disposition 1 ☐ Burial 2 ☒ Crema 4 ☐ Donation 5 ☐ Ott		from State	20b. Place of cemetery R.A. F	, cremato erris	ry or other place	10–8–	2007	West (	tion - City or T Cheste	
Bal	permit. Page Department Important: I any injury or once,		21. Signatu In 196	hanu	ī.		22. Na Tari 333	me and Addres ing-Cai S. Parl	rgo Funer ke St, Ab	al Home	P.A MD 2	<b>i</b> 001	
			23a. Part 1. Enter the diseas shock, or heart failure.	e, or complications to list only one cause of	hat caused then each line.	e death. Do no	ot enter the	e mode of dying	g, such as cardiac o	or respiratory ar	rest,		Approximate Interval Between
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8760		Medi	IF FEMALE:								1		
. Box 68	law "equires that the death certificate be executed has been signed by the attending physician and e.2 should be detached for use as the burial-trans.		23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown	1 1 1	, outcome of p Live Birth 2 [ Pregnant at tir Unknown	Fetal death		topic pregnancy ner (specify)	у		230	d. Date of deli Month	very Day Year
ls, P.O.	uires that the signed by all the deta	þ	Part II. Other significant con	ditions contributing	to death but	not resulting in	the under	lying cause give	en in Part I.				the cause of death?
Division of Vital Records,	law has e 2 s	Completed			· · · · · · · · · · · · · · · · · · ·				_	24a. Was autor perfo		prior to c death?	opsy findings available ompletion of cause of
tal	sician: The certificate rect r, pag	Be	25. Was case referred to med examiner?	cal Hospital:					ace of Death (Check		(		
Ž	Physic r this c	<u>۲</u>	1 ☐ Yes 2 ☐ No 27. Manper of Death		1 ☐ Inpatient Date of injury	2 ER/Out			4 L Nursing Ho	me 5 D Resid			fy)
o uc	nding ath. r: After e fune	icate	Natural 5 ☐ Pe		Month, Day, Y		jury	28c. Injury work? 1 1 1	Yes 2 \( \sum \) No	28d. Desorbe r	ow injury oc	ccurred	
Division	al or Atters after de la Directored in by the	l Certificate:			lace of Injury uilding, etc. (S	- At home, farm Specify)	n, street, f	actory, office		28f. Location (S City or Tow		umber or Rura	al Route Number,
2	To the Hospital or Attending Physiciam: within 24 hours after death. To the Funeral Director: After this certific completed filled in by the funeral direct or,	Medical	(Check 2 Medic only one) 3 Certif	ving Numa Practice	basis of exan	nination and/or	investigati	on, in my opinio	n, death occurred at	the time, date a	and place, and	d due to the ca	ause(s) and manner stated.
	To t To t		29b. Signature and title of cer	titer				29c. License	number 66912	2	29d. Date si	igned ( <i>Month</i> ,	day, Year)
_			30. Name and address of persons of persons A	10 602	cause of deat	h (Item 23a) (Ty HWOO	ype, Print)	Suite.	200, Be	(Air)	MO	210	14
	Stat Registra		31. Date filed (Month, Day, Yea		2. Registrar's	Signature	ace						

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year ANSEN DFLINA 5:20 DM 05-2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death CROMWELL ARKVILLE BALTIMERE CENTER 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 1 ☐ M 2 🔀 F Months Davs Hours Min 212-09-6861 5-3-1916 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits Parkville 1 ☐ Yes 2 X No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21234 8710 Emge Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 【XNO Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2 🗓 No Specify. Specify: White 3 Nidowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Raleigh Cloth's College (1-4or 5+) Accountant 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DiPietro D'Andrea Gaetano Ann arella 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 Chantery Drive BelAir, Md. 21015 Alfred DiPietro - Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Sacred Ht.of Jes. 10-10-09 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 21. Signature of uneral Service License 22. Name and Address of Facility Joseph N. Zannino Jr. 21224 263 S. Conkling St. Balto. Md. 23a. Part 1. Enter the disease shock, or heart failure. e, or mulications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Liv onlone cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SHOCK SYNDROME disease or condition resulting in death) Due to (or as a consequence of) SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events PNEUMONIA resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mor Month 5 Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STAGE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Inversing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 ∃Natural 1 Tyes 2 🗆 No 2 Accident

Physician /Medical Examiner

permit. Pages 1 and 2 should be file Department of Heatth and Mental Hy Important: If item 27 is marked othany injury or other traumatic event

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

2

Be

is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Examinar must be matified at

Baltimore, Maryland 21215-0036

burial-transi physician a use as attending signed by the a been has

P.O.

of Vital Records,

Division

Examiner Physician/Medical þ Completed certificate Be Certification: To

funeral director, After this To the Hospital or Attending after death.

I Director: Af d in by the fur filled in by within 24 hours a

13

Medical

Registrar

FERNANDO 31. Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier

6 ☐ Could not be



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DELCADOMO

D 32717

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 2009

28f. Location (Street and Number or Rural Route Number, City or Town, State)

06

32. Registrar's Signature

			1 - For State Registrar	State of Maryland			of Health of Death			ene	9	32088
	Physici /Medic		Decedent's Name (First, Middle, Last)     Doodnauth Jagernaut	th					Date of Death Month ctober	Day	Year 9	3. Time of Death 10 :30 A M
	Examin	er	4a. Facility Name (If not institution, give st. Manor Care Rossville			R	wn, or Location osedale				f Death ltim	
	Funeral Director		215 33 7393	7. Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Months D	ear If Under lays Hours	Min. Ar	Date of Birth (Month, Day, Oril 27	,1933 (	9. Birthp Cour Guya	place (State or Foreign ntry) Na
	Maryland -f show	tor	Usual Residence of Decedent  10a. State  10b. County  Maryland Baltimore	10c. City	Town or Lo						1	10d. Inside City Limits 1 ☐ Yes 2 ☑ No
	3a or 28e	ai Direc	10e. Street and Number 1503 Nicolay Way			10f. Zip Co	nde 1221		10	g. Citizen of Wi		ntry?
336	72 hours after death with the Maryland inetural; or tems 23s or 28e-f show disal Examinat must be notified at	by Funera	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	2. Was Decedent Ever in U.: Armed Forces? 1		Was Decedent Yes, specify	t of Hispanic O Cuban, Mexica No Specify		y Yes or No- an, etc.)	Black	, White,	can Indian, etc. n Indian
21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural; or itema 23a or 28e-f show entry or other traumatic event, the Madical Examinat must be notified at an ance.	Completed by Funeral Director	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) Coflege (1-4or 5+)	(Give	dent's Usual C kind of work of DO NOT use	done during mo retired)	st of working	1	6b. Kind of Bus		dustry
Maryland 2	uid be filed Aental Hygi rked other tic event, I	ae B	17. Father's Name (First, Middle, Last) Ram Jagernauth				18. Moth		irst, Middle, M	laiden Sumame		
	alth and N		19a. Informant's Name/Relationship (Typ Tony Jaggernauth (Sc							City or Town, S		
Baltimore,	Pages 1 6 ment of He tant: if item lury or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State  20b. Post	ace of Dispo	sition (Name	of	Date	2	Oc. Location - 0	City or To	
Ball	Depart Depart Import eny in		21. Signature of Funeral Service Licenses	rkouske	Br 14	uzdzin 07 Old	_	eral H n Aven	ue Esse	ex, Mar	ylan	d 21221
	Physician physic	Examiner	23a. Pah1. Enter the disease, or complic shock, or heart failure. List only one immediate Cause (Finaf disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	POTIC uence of):				•			Approximate Interval Between Onset and Death
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	quires that n signed t uld be det	þ	Part II. Other significant conditions cont	ributing to death but not resu	ulting in the u	nderlying cau	se given in Part	1.			ibute to t 3 ☐ Proi	the cause of death? bably 4 Minknown
Il Records,	The law requires that the rate has been signed by the page 2 should be detache	Completed							24a. Was ar autopsy perform 1 Yes 2	pled? d	rior to co	opsy findings available ompfetion of cause of
f Vita	ding Physicien: The In. After this certificate ha funeral director, page	To Be	25. Was case referred to medical examiner?  1 \( \text{Yes} \) 2 \( \text{Vo} \)	ospital: 1  Inpatient 2	ER/Outpatien	at 3□ DOA	Other	ursing Home	Check only one	nce 6 □Othe	ır (Speci	fy)
Division of Vital	Attending Phrdeath.		27. Mannel of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of fnjury (Month, Day Year)	28b. Time of fnjury	M 280	Injury at Work?		d. Describe ho	w infury occurre	ed .	
Divis	= = ± = =	Certification;	3 Surcide 6 Could not be determined	28e. Place of fniury - At ho building, etc. (Specify	<i>'</i> )				City or Town	, State)		ral Route Number,
	To the Hospital within 24 hours a To the Funerei Completely filled	<b>l</b> edical	(¢heck only 2 Medical Examin	iciam: To the best of my kno er: On the basis of examinal and manner stated.	wiedga, daall tion and/or in	vestigation, ir	my opinion, de	eath occurred	at the time, da	ite and place, a	ind due t	to the cause(s)
)	or viti	Σ	29b. signature and title of certifier	)			icense number			Od. Date signed		
ŀ	11		PANKAT KHETEZPI	npleted cause of death (Item  9106 PH	23a) (Type,	Print)	RD #	20%	BALTI	more (	M	5,2009
1000	Sta Registi		31. Date filed (Month, Day, Year)  OCT 0 7 2009	32. Registrar's Signa	bar	4						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month AUI TOBER 200 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** The Johns Hopkins Hospital **Baltimore City** n/a 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 6. Sex Date of Birth (Month, Day, Year) **Funeral** Months 216-42-1929 Director 65 July17,1944 MD Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Director 1 Xes 2 No MD n/a Baltimore 10e. Street and Number 10g. Citizen of What Country? or items 23a or 1519 E. Biddle St. 21213 Funeral USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 If Yes, Give Year or Dates: 2 XNo 1 Never Married 2X Married 1 Yes 2 No Specify ģ Specify: Black 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) 9th Sanitation Worker <u>Baltimore Citv</u> and Mental Hygie is marked other 17. Father's Name (First, Middle, Last) other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) Be Virginia Jefferson ည John Paul Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 a Department of Health ar Important; If item 27 is any injury or other trau once. Barbara A. Jones/Wife 1519 <u>E. Biddle St.</u> Baltimore, MD 21213 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Parkwood Cemetery Oct.12,2009Balto.,MD Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTIMORE MD 21213 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be exe physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth in the past 12 months? 2 Fetal death 3 Ectopic pregnancy Day Month Year Pregnant at time of death 5 Other (specify) Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Inpatient 1 ☐ Yes 2 No မ 2 ER/Outpatient 3 🗌 DOA 4  $\square$  Nursing Home 5  $\square$  Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I Director: After the funer of in by the funer 5 Pending investigation (Month, Day Year) Injury 2 □ No 2 Accident 1 Yes after death Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide City or Town, State) within 24 hours a

To the Funeral D

completely filled 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical

3 State

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

30. Name and dress of person who completed cause of death (Item 23a) (Type, Print) Lew. MN 31. Date

29b. Signature and title of certifier

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

32. Registrar's Signature.

Registrar

2 in Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

RF5-000

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) october 6 200<sup>8</sup> 10:10 AM Physician/ Leah M. Joyce Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Anne Arundel 7809 Baffin Court Severn 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Social Security Number Funeral Days Hours Min 1 □ M 2 🗓 F ,1927 Pennsylvania 82 202-18-7750 Director Usual Residence of Decedent 10d. Inside City Limits show 10b. County 10c. City, Town or Location 10a. State with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🕅 No MD Anne Arundel Severn 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral United States 21144 7809 Baffin Court within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married ☐ Yes Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 XWidowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 l
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "nr
any injury or other traumatin. (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Insurance Book Keeper Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Mary V. Mitchell Harry W. Meredith 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13 Sandwood Drive, New Castle, DE 19720 Dierdre M. Schuller, Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery crematory or other place)
Lansdale Crematory 1 Burial 2 X Cremation 3 Removal from State Lansdale, Pennsylvania 10/10/2009 4 Donation 5 Other (Specify) 22. Name and Address of Facility Moore & Snear Funeral Home 21. Signature of Fune A Service Licensee T. Harman 19 East Germantown Pike, East Norriton, PA 19401 7 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 3m05 ~Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) 3m<u>os</u> Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy Month Year in the past 12 months?

1 Yes 2 No Pregnant at time of death signed by the all d be detached for g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 2 No page 2 s certificate has 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 1 🗌 Yes 2 ANO 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ဂ္ this 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: After Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined City or Town, State) Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical

20

29a. Certifier (Check

only one)

29b. Signature and title of certifier

Date filed (Month, Day,

and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

State Registrar Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Date signed (Month, Day, Year)

2106

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day September 7:15PM Jeffrey Scott Kline, Sr. 30 200 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Healthcare AGNES SAINT BAUTIMORES If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2□ F Months 266-65-3303 27, 36 Oct. 1972 Virginia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☑ Yes 2 ☐ No Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3102 Wilkens Avenue 21223 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🛛 No Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 Great Falls Septic Truck Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Theodore M. Kline Virginia A. Harmon 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Lynn Kline (Wife) 3102 Wilkens Ave., Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 Dopation Olive Cemetery 10/5/09 Hayfield, VA 21. Sign flure of Funeral Service Lense <sup>22</sup>. Name and Address of Facility Jones Funeral Home, Inc. 228 S. Pleasant Valley Rd., Winchester, VA 22601 Dunis Umn 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cancel MALLOWA Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 1 ☐Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 No 1 ☐ Yes 2 🖼 No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No 1 🗌 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 🔁 Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Examiner Division of Vital Records, P.O. Box 68760

physician and the burial-trans ned by the attending p detached for use as ate has been signed by page 2 should be detac certificate has been completely filled in by the funeral director, Hospital or Attending Phys 24 hours after death. Funeral Director: After this

Physician

/Medical

Director

Funeral

β

Completed

Be ပ္

Examiner

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any Injury or other traumatic event, the Mariani Earland and any Injury or other traumatic event, the Mariani Earland and any once.

**Physician** 

/Medical

Examiner

Physician/Medical

2

Completed

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Certification: To

Medical

4 Homicide

29a, Certifier (Check only

Baltimore, Maryland 21215-0036

To the within 2 To the I

State

Registrar

29b. Signature and title of pertifier

Hun

29c. License number

5029

BALTIMORE

to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Sentember 30, 2007

30. Name and addless of person who completed cause of death (Item 23a) (Type, Print)

Ben ST Agne

31. Date filed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Mary Elizabeth Kidd September 26,2009 6:50 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Calvert County Nursing Center Prince Frederick Calvert 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) July 15,1919 9. Birthplace (State or Foreign Months Days 1 □ M 2 💢 F Hours Virginia July 229-26-7988 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 □Yes 2 No Maryland Calvert Huntingtown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 255 Bowle Shop Road 20639 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 X No White Specify: Specify: 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 U.S. Government Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Noah E. Hottle Barbara Mae Matthias 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Barbara Volonakis-Fowler/Niece 255 Bowie Shop Road, Huntingtown, Md. 20639 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Pk: 9/30/2009 Falls Church, Va. 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign and of Funeral Service License 22. Name and Address of Facility CC0508 Gary R. Downer | Money & King Funeral Home, 171 W. Maple Ave. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Vienna, Immediate Cause (Final disease or condition resulting in death) CARCINOMA -OL Due to (or as a consequence of) Sequentially list conditions, if ny Lean Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? MAINGPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nokhown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1

**Physician** /Medical **Examiner** 

death certificate be executed

Box 68760.

P.0.

Division or Vital Records,

**Physician** 

/Medical

Examiner

Funeral

Director

show

r 28a-f show notified at

De filed within 72 room. stal Hygiene. sed other than "natural", or items 23a or 28r sed other than "natural", or items 23a or 28r seont, the Medical Examiner must be no

d 2 should be filed w th and Mental Hygies 7 is marked other th

permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra

traumatic event.

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

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Examiner burial-transit and physician Physician/Medical for use ed by the a detached f δ Completed Be 2 funeral

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filled in by

the Hospital or Attending nin 24 hours after death.

Certification:

Medical

9 Unknow 25. Was case referred to medical examiner?

28a. Date of Injury (Month, Day Year)

26. Place of Death Check onl on Other: 4 ☐ Vursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

5 Pending

investigation

6 Could not be determined

D50233

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Glynis Moody, MD

1 🗌 Yes

27. Manner of Feath

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

110 Hospital Rd., #210, Prince Frederic, Md. 20678-4041

Registrar

31. Date filed (Month, Day, Year) OCT 07 2009



1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month OCTOBER Year 2009 **Physician** 6:07 A M KATHY LYNN KING /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK FREDERICK FREDERICK MEMORIAL HOSPITAL Birthplace (State or Foreign Country) If Under 1 Year \_ If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🔀 F 48 Maryland Feb. 15, 1961 Director 217-82-2072 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show 1 ☐ Yes 2 No Frederick Frederick Maryland Direct 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21701 U.S.A. 8501 Chestnut Grove Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ∏Yes 2 XNo Specify: Specify: ≥ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) daycare provider/homemaker own home 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Charles William Stine Virginia Stevens 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any Injury or other tra Frederick, MD 21701 8501 Chestnut Grove Rd. Thomas W. King/ husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State St. Peter's Cemetery 10/5/2009 Libertytown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Signature of Formeral Service Lic & affarine Libertytown, MD 21762 11802 Liberty Rd. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dyling, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nte Immediate Cause (Final res **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner A te enmonia bi Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Stag sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown ned by the 9 🗌 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performer 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 124 hours after death. Funeral Director: After this certifica filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Division (Month, Day, Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 24 hours a X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 10/2/2009 a MDD35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Myung Hee Nam 400 W. Seventh St. Frederick, MD 21701 31. Date filed (Month, Day, Year 32. Registra/s Signatur State Registrar

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

Physician /Medical Examiner

**Funeral** 

For State Registrar

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division or Vital Records, P.O. Box 68760, So To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

1. Decedent's Name	(First, Middle, Las	AMIZO,	*(7)					2. Date of Death Month  COBSA	Day	2009		ne of Dea	
4a. Facility Name (II	not institution, give	e street and number)	<i>NO</i>	4	4b. City, Town, c			CIUBIAL		ounty of Dea			
	ss Nursing a				Burtons				M	ontgome			
5. Social Security N 216-11-426 Usual Residence of	54 1	ex 7. Age	53		If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day, January	3, 195	6 Ja	thplace (St ountry) ipan	ate or Fo	reign
10a. State	10b. County		10c. City, To	wn or Loca	ation			, , , , , , , , , , , , , , , , , , , ,			10d. Insid	de City L	imits
Maryland	Howard			Colum	mbia						1 🗆	Yes 2	Ď No
10e. Street and Nur					10f. Zip Code			11		n of What C	ountry?		
6797 Pyrami	id Way				210				Jap				
11. Marital Status 1 □ Never Marri 3 □ Widowed	ed 2 <b>K</b> Married 4 □ Divorced	12. Was Decedent B Armed Forces? 1  Yes 2			as Decedent of H Yes, specify Cub ☐Yes 2፟፟፟X No	lispanic Ori an, Mexicar Specify:	gin? (Spe n, Puerto F	cify Yes or No- Rican, etc.)		. Race - Am Black, Whi pecify: Ja			
(0	15. Decedent's Ed	lucation	16	Sa. Deceder	nt's Usual Occuj	ation	4 - 5   -	. 1	16b. Kind	of Business	s/Industry		
Elementary/Seco	ify only highest gra ndary (0-12)	College (1-4or 5	+)	life. DC	nd of work done O NOT use retire	auring mos d)	t ot workir	ng	_				
		2		Homer	maker				Own				
17. Father's Name (		1						(First, Middle, M ıruta Tazı		,			
Korehiko Ki	-	Time Print)	10	Oh Mailing	Address (Street						Zin Codal		_
Yohachiro I		(Husband)	"		Pyramid Wa			a, Marylar	-		zip code)		
20a. Method of Disp		(Hastaila)	20b. Place		tion (Name of atory or other pla					tion - City o	r Town, Sta	te	
	Cremation 3 ☐ 5 ☐ Other (Specify	Removal from State	Atlant				10-3-2	2009	Glen B	burnie,	Marvla	nd	
21. Signature of Fu				Wii	Name and Addre tzke Fune 55 Twin Ki	ss of Eacilit	es, Ir						
23a. Part1. Enter the	ne disease, or com	plications that caused one cause on each lin	the death. Do								Approx	kimate Il Betwee	en
Sequentially list confiant, leading to incause. Enter Unde Cause (Disease or that initiated events resulting in death) I	infiediate rifying injury	cDue to (or as a											
if any, leading to it cause. Enter Unde Cause (Disease or that initiated events resulting in death) I.  if FEMALE: 23b. Was deceden in the past 12 1  Yes 2  9  Unknown  Part II. Other signif	months?	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal dea		Ectopic pregnanc	у			230	d. Date of do Month	elivery Day	Yea	ar
Part II. Other signif	ficant conditions of	contributing to death bu	ut not resulting	in the und	lerlying cause gi	ren in Part I		23e. Did tob		contribute		e of deat 4 <b>I</b> onk	_
						<u>-</u>		24a. Was a autops perforr	med?	24b. Were a prior to death? 1 □ Ye	completion	of caus	ilabl e of
25. Was case refer examiner?	red to medical					26. Place	of Death	(Check only on					
1 ☐ Yes 2 ☑		Hospital: 1 ☐ Inpatie		Outpatient	3□ DOA Oti	4 L# TVI		ne 5 🗆 Reside			ecify)		
27. Manner of Deat  1 ☑ Natural  2 ☐ Accident	5 ☐ Pending investigation			o. Time of Injury	28c. Inju Wo M 1	ryat rk? Yes 2 ☐		28d. Describe ho	ow injury o	occurred			
3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could not be determined	28e. Place of injubulding, etc	ury - At home, c. (Specify)	farm, stree	et, factory, office		2	28f. Location (St City or Town	reet and I n, State)	Number or I	Rural Route	Number	r,
29a. Certifier (Check only one)	1 Certifying Ph	nusician: To the best of miner; On the basis of and manner sta	examination									use(s)	
29b. Signature and					29c. Licens			1		signed (Mor	nth, Day, Ye	ar)	
· m	) CH	AM			808	385	2_	Φα	1069	LZ,	2009	?	
30. Name and addr	ess of person who	completed cause of de	eath (Item 23a	a) (Type, Pr	rint) - R 5 1 3 7 3 7	(S.TON)	yu	21130	4				
31. Date med (Mon	th, Day, Year) 0 7 2009	32. Registra	ar's Signature	and I									

State Registrar

		State of Marylan 1- State Amend Item 26 per dr., g896		rtment of H /09dhb rtificate of I	lealth and M D <i>eath</i>	lental Hyg	iene <sub>eg. No.</sub> 2009	82095
Physic /Medi		1. Decedent's Name <i>(First, Middle, Last)</i> Martha M. Long				2. Date of Death October		3. Time of Death 9:30P M
Exami		4a. Facility Name (If not institution, give street and number)  Manor Care Rossville		4b. City, Town, or Baltimore	-		4c. County of Death Baltimore	
Funeral Director		5. Social Security Number 216 05 0530 6. Sex 1 M 2 F 98	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, November	9. Birth 23 1910 Balti	place (State or Foreign ntry) nore,Maryland
Maryland -f show	tor		y, Town or Lo				1	10d. Inside City Limits 1 ☐ Yes 2 ☐ No
h with the 23a or 28a st be noti	al Director	10e. Street and Number 7142 Willowdale Avenue		10f. Zip Code 21206		11	0g. Citizen of What Coul	ntry?
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expriment must be notified at any injury or other traumatic.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  XX Widowed 4 □ Divorced  12. Was Decedent Ever in U. Armed Forces?  1 □ Yes 2 7 No  If Yes, Give  Year or Dates:	'	Was Decedent of H If Yes, specify Cuba 1 □ Yes 2XXNo	ispanic Origin? (Spenn, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whit	etc.
Maryland 21215-0036 d 2 should be filed within 72 hours aft th and Mental Hygiene. 77 is marked other than "natural", or traumatic event, the Medical Exertit	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  N/A	(Give	DO NOT use retired	during most of workii	ng	16b. Kind of Business/In Chesapeake Sho	•
and 2 abd filed butal Hygi red other	Be C	17. Father's Name (First, Middle, Last)  Matthew Fritsch	Couns	.000	18. Mother's Name			30 00.
Maryl nd 2 shoule th and Me 27 is mark	2	19a. Informant's Name/Relationship (Type. Print)  Dolores Czernikowski		ng Address (Street )	and Number or Rura	al Route Number	; City or Town, State, Ziparyland 21206	p Code)
altimore, rmit. Pages 1 ar partment of Hee portant: If item y injury or othe	l i	20a. Method of Disposition  20b. F	Place of Dispo cemetery, cren	sition (Name of natory or other plac Redeemer Cer	re)	Date	20c. Location - City or To Baltimore ,Mary.	
Balti permit. Departr Importa any inji		21. Signature of Funeral Service Licensee	1 -	7401 Belair	ss of Facility eral Home Ir Road Baltin	nore. Mary	land 21236	
Physician /Medical	X E	23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	h. Do not ent	er the mode of dyin	ng, such as cardiac o	or respiratory arr	est,	Approximate Interval Between Onset and Death
Examiner	er	Due to (or as a consequentially list conditions, if any, leading to immediate  Due to (or as a consequentially list conditions, if any, leading to immediate	·					
18760, icate be executed physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Line Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of the consequenc	uence of):					
death certif	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnat 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of 0 9 □ Unknown	Ideath 3	☐ Ectopic pregnanc ☐ Other (specify)	у		23d. Date of delive Month	very Day Year
_ 2 5 0	by	Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		pacco us <i>e</i> contribute to e	
al Records,  The law requires the cate has been signe, page 2 should be d	Completed					24a. Was a autops perforr 1 □ Yes	y prior to co	opsy findings available ompletion of cause of
of Vital F Physician: Th this certificate al director, pag	To Be (	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ Mo Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 □ DOA Oth	26. Place of Deather: 4 X Nursing Ho	-	e) ence 6  ☐ Other (Spec	ify)
Ter in	Certification: 7	27. Mann of Death 1 Natural 5 Pending Investigation 3 Suicide 6 Could not be determined	28b. Time of Injury	f 28c. Injur Worl	yat ⟨? Yes 2 □ No	28d. Describe ho	ow injury occurred treet and Number or Rui	
Division  The Hospital or Attendir  The Hours after death.  For Inneral Director: After fulled in by the fulled in		4 ☐ Homicide building, etc. (Special building, etc.)  29a. Certifier (Check only 2 ☐ Medical Examiner: On the basis of examinary of the basis of th	fy) owledge, deat	h occurred at the til	me, date and place,	City or Town	n, State) cause(s) and manner as	stated.
To the Hos within 24 ho To the Fun completely	Medical	29b. Signature and title of certifier		29c. Licens			9d. Date signed (Month)	
	8 2	30. Name and address of person who completed cause of death (Iter	n 23a) (Type,	Print) tham	Words	Long	W-MD	21234.
Sta Regist		31. Date filed (Month, Day, Year)  OCT 0 7 2009  Registrar's Signa		Kal				*

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Year **Physician** 1404 PM 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospita Age (In yrs. last birth Birthplace (State or Foreign Country) Date of Birth (Month, Day, Social Security Number Funeral 1 □ M 2 🕽 F Months Days Hours 2-15-11 Director Usual Residence of Decedent 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marical Expriser raiss be notified at once. 10a State 10b. County 10c. City, Town or Location 1XYes 2 ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Specify þ 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/86 condary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Hural Route Number, City or Town, State, Zip Code) Baltin Dauahter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatury of Funeral Service Licensee MO1553 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Myolardi Immediate Cause (Final bable **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to indirectate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Die to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transi Exam Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown 9 🗀 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗆 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐Yes 2 ☑No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Division of Vital Records,

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

Medical 29b. Signature and title of certifie

1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) October 5, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Terrarce L. B. Ker MD Good Scheeten

and manner stated

Haspital Bultimire

31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29a, Certifier

2009 OCT 07

32. Registrar's Signature

Registrar

State of Maryland / Department of Health and Mental Hygiene

2009 32097

			I- For State	(	Certificate c	of Death			Reg. No.	Bases Facility St.	
	Physicia		Registrar 1. Decedent's Name (First, Middle,Las	t)				2. Date of			3. Time of Death
Лe	dical Exami		Michael Lagrasse					Month Septer	nber 26, 2009	Year	0744 hrs
			4a. Facility Name (if not institution, give	e street and number)		4b. City, Town, c	r Location of	Death	4c. Coun	nty of Death	
			308 S. Broadway Street			Baltimore					ļ
	Funeral		5. Social Security Number 6. Se	7. Age (In y	rs. last birthday)	If Under 1 Ye	ar If Under	24Hrs. 8. Date of	of Birth(MM/DD/YY	(YY) 9. Birt	hplace (State or
	Director			l., all =	V	Months Da	ys Hours	Min.		Foreig Cou	untry)
		ŀ	- CATTAL	M 2 F	48 Y	5.		l_Oct	21, 1960		NY NY
	any	ł	Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Loca	ation					10d. Inside City Limits
	<b>*</b> "	- 1	look standy		,,						1 XX Yes 2 No
	Maryland 28a-f show d at once.	힏	MD		Baltimore	1405 71 011			10g. Citizen of	What Cour	atn/2
	Mary 28a- d at	Director	10e. Street and Number			10f. Zip Code			lug. Citizen of	What Cour	iti y r
	th the Maryland 23a or 28a-f sho notified at once.		308 S. Broadway Str	eet		212	205			USA	
0	with ns 23 be no	Funeral	11. Marital Status	12. Was Decedent Ever		as Decedent of H Yes, specify Cuba				lace - Ameri Vhite, etc.	can Indian, Black,
	r death or iten	š	1 Never Married 2 Married		No "	res, specify Cub	ali, ivicxicali, i	derio Moan, cio.	′   ''	Tinto, Oto.	
	fter (I'', o		3 Widowed 4 XX Divorced	If Yes, Give Year or Dates:	1	Yes 2 XX N	lo specify:		Speci	ify: W	hite
	136 thin 72 hours afte ne. than "natural", edical Examine	Completed by	15. Decedent's Education (Specify of			ent's Usual Occup			16b. Kind of	f Business/I	ndustry
	72 ho	ë	Elementary/Secondary (0-12)	College (1-4 or 5+)	during	most of working li	re. DO NOT u	se reurea)			
	136 thin he than	훁	12		M	lechan <b>i</b> c			Au	uto	
	5-0036 Ited within 7 Hygiene. I other than the Medica	힍	17. Father's Name (First, Middle, Last	)	\		18.Mother's	Name (First, Mid	dle, Maiden Surna	ame)	
	e file ral He ked o	Be (	John A. Lagrasse				Patr	icia L. Mj	marik		
	MD 21215-0036 2 should be filed within 72 hours after death with the Maryland hand Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shomatic event, the Medical Examiner must be notified at once	10	19a. Informant's Name/Relationship (	Гуре, Print )	19b. Mail	ng Address (Str	eet and Numb	er or Rural Route	Number, City or	Town, State	, Zip Code)
	MD d 2 sho lith and m 27 is aumati					<b>6</b> .	D ( N	011 111	40056		
	e, MD 21215-003 1 and 2 should be filed within Health and Mental Hygiene. item 27 is marked other th		Karen A. Lagrasse 20a. Method of Disposition		204 20b. Place of Disp	osition (Name of o	cemetery,	Date	20c. Locati	ion - City or	Town, State
	of H		1 XXBurial 2 Cremation 3	Removal from State	crematory or Summ <b>i</b> t Park			Oct 3, 200	Now He		d NIV
	Fag ment		4 Donation 5 Other Specify						1 New Tie	empstea	u, IVI
	Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 Injury or other traur		21 on ature of Funeral Service Lines		/ 22	Name and Addre					
	m gazz	1	Milliography A	MUIT48					nie, MD 210		Approximate Interval
	Physician		23a Part I. Enter the disease, or completely one cause on earlier	ach line.			g, such as ca	rdiac or respirato	ry arrest, snock, or	rnean	Between Onset and
	/Medical xaminer	3	Immediate Cause (Final disease a.	Narcotic i	ntoxicat	ion					Death
	Kallillei		or condition resulting in death)	Due to (or as a conseque	nce of):						
		_	Sequentially list conditions, b.								
		ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a conseque	nce of):						ļ. i
		Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a conseque	nce of):						
10	ansit ansit		d								
5	760, cate be executed physician and the burial - transit	/Medical	XUNPENDED	AMENDED 23a,2	27,28a-f	eprME, {	3896 10	1 <del>/9/09</del> T	T		
	e be ysiciz	edi	IF FEMALE:	23c. If yes, outcome of	programmy	······			23d Dat	te of deliver	v -
	376 ificate ig phy s the		23b. Was decedent pregnant in the	1 Live birth	pregnancy	Fetal death	3 Ectopic	pregnancy	Mon		Day Year
	ox 68 eath certifi attending for use as	Physiciar	past 12 months?	4 Pregnant at time	- (	Other (Specify)			!		
	30) death	ıysi	1 Yes 2 No 9 Unknow	n g Unknown							
	ires that the de signed by the		Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying caus	e given in Par	t I. 23e.	Did tobacco use o	contribute to	the cause of death?
	es tha	þ						1	Yes 2 No	3 Pro	obably 4 🗹 Unknown
	cords, law require has been si	Completed						24a.		4b. Were a	utopsy findings available
	law r has b 2 sh	효				<del></del>			autopsy performed?	prior to death?	completion of cause of
	Recare cate	ĕ						1 🗸	Yes 2 No	1 🗸 Y	es 2 No
	tal Reco	Be (	25. Was case referred to medical examiner?			26.Pla		Check only one)			
	Vit nysle this c	0	1 ✓ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpation		Other <sub>4</sub>	Nursing Home	5 Residence	6 🗸 Othe	er: Scene
	ing Pt After After Tuneral	<u> </u>	27. Manner of Death	28a. Date of Injury (Month, Dey, Year)	28b. Time		njury at Work		cribe how injury or	ccurred	
	On endivath.	tio	1 Natural 5 Pending	E4 0/26/0	9 unk	1_	Yes 2X	No unk			
	risi r Att er de irect	lica	2 Accident Investigat 3 Suicide 6 X Could not	29o Place of Injury		treet, factory, offic	e building, etc	28f. Loca	ation (Street and N	umber or R	ural Route Number, City Braodway
	Div tal o	Certification:	4 Homicide determine					Balt	imore, M	Ď	
	lospi 4 hou fune			cian: To the best of my kn	owledge, death oc	curred at the time	, date and pla	ce, and due to th	e cause(s) and ma	anner as sta	ated.
	Division of Vital Records, P.O. Box 68760, A. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial _transi	Medical	one) 2 Medical Examine	er:On the basis of examina	tion and/or investi	gation, in my opin	ion, death oc	curred at the time	, date and place, a	and due to t	he cause(s)
	To To com	Med	29b. Signature and title of certifier	and manner stated.		29c. Lice	ense number		29d. Date	signed (M	onth, Day, Year)
		_	11/10/11	1			C.M.E.		Septem	nber 26,	2009
	1		buth	em)		<u> </u>					
	$\Phi$		30. Name and address of person who			nn Chrost D-	ltimore AA	D 21201			
	Į.			stant Medical Exami		nn Street, Ba	iditiore, M	21201			
	S	tate	31. Date filed (Month, Day, Year)	32. Registrar's S	signature						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 05 Odell Leach /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimor If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 90 1 XM 2 □ F 359 07 4277 1919 Kentucky May 16, Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It we World's Evan in a nation once. 10a. State 1 ☐Yes 2 ☑No Director Baltimore Essex Maryland 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number USA 20 Seaford Avenue 21221 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☆ Yes 2 □ No If Yes, Give Year or Dates: WW II Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ No Specify: White 2 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Aerospace Assembler 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Reaves James Leach ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20 Seaford Avenue Baltimore, Maryland 21221 Ruth A. Leach (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holly Hill Mem. Gardens 10/8/2009 Baltimore, Maryland 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 21. Signatur of Funeral Service License DUCKOUDIO halt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Preumonia Immediate Cause (Final WECK Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ocamia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Die to (or as a consequence of): Fibri Mation physician and s the burial-trans Due to (or as a consequence of): Physician/Medical as t attending properties for use as IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day ☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown is been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an cate has t page 2 s autopsy performe 2 No 1 🗆 Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 ₩ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To Date of Injury (Month, Day, Year) 28c. Injury at Work? 27, Manner of Death 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide

The law requires that the death certificate be executed Ö ₫. Division of Vital Records, or Attending Physician:

Box 68760

the

certificate

72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within nent of Health and Mental Hygiene.

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu To the Hospital Medical Y

State Registrar 29a. Certifier

(Check only one)

29b. Signature and title of

30. Name and address of

person who completed ca

use of death (Item 23a) (Type, Print)

1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

square Dr

29d. Date signed (Month, Day, Year)

#### Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** OCTOBER WILLIAM F. LOGAN /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8546 PLEASANT PLAINS ROAD TOWSON If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1**X** M 2□F Days Hours Months Min. Yrs. 131-20-6043 Director 1/7/1930 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 28a-f show the Medical Expreiner meet be notified at Director TOWSON MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or 21286 8546 PLEASANT PLAINS ROAD Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married Married Baltimore, Maryland 21215-0036 "natural", or If Yes, Give Year or Dates: KOREA 1 □Yes 2 □XNo Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) 4 YEARS ELECTRICAL ENGINEER Pages 1 and 2 should be filed vent of Health and Mental Hyginut: If item 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ANGELICA SEUBERT MICHAEL LOGAN ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. MIRIAM E. LOGAN/WIFE 8546 PLEASANT PLAINS RD. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-9.09 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fune al Service Licensee MOO217 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. 23a - it1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final itostic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. þ 1 ☐ Yes Completed 24a. Was an autopsy performe 1 □Yes 2 [ 25. Was case referred to medical examiner? Be 26. Place of Death (Check oply one) Hospital Other: 4 Nursing Home 1 ☐ Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of

5 ☐ Pending investigation

6 ☐ Could not be

determined

2 Accident

3 Suicide

29a. Certifier

29b. Signature

4 Thomicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

14. Race - American Indian Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry ELECTRIC COMPANY TOWSON, MD<u>21286</u> 20c. Location - City or Town, State BALTIMOUS MERHAGE TOWSON, MD Approximate Interval Between Onset and Death 23d. Date of delivery Month Year 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 2 No Flesidence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) Charles St., Suite 5105

3. Time of Death

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 ☐ Yes 2 ☐ XNo

NEW YORK

11:30 PM

2009

BALTIMORE

USA

State Registrar

Medical

within 24 hours a

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

6901

and manner stated.

lan

32. Registrar's

330UN 10313

completed cause of death (Item 23a) (Type, Print)

CMS

1 ☐ Yes

2 🗆 No

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. AMEND TIEM# 9perFH, 6896, 10/8/09, WS State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Roland Langley William 2009 10 02 4:10p. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Baltimore Harbor Hospital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Months Days Hours Min 1 M 2 □ F Maryland 219-26-8999 Director 70 39 16 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show ir than "natural", or items 23a or 28a-f show Mo Yes 2 No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 U.S.A. 1006 Shellbanks Road Apt B-1 r death v Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 XNo Specify: þ 3 ☐ Widowed 4X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatte event, Ite Mo Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 9th grade na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willa Mae Wynn William R. Langley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3305 Cardenas Ave, Baltimore, Md 21213 Karen Langley-Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/9/2009 | Baltimore, Md On-Site 22. Name and Address of Facility
March F/H West 21. Signalure of Funeral Service Lic mala 4300 Wabash Ave, Baltimore, Md 21215 23a. P . 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardiougopathy **Physician** Ischeamic 12015 /Medical Due to (or as a consequence of): KUVS Examiner oronary Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Ye ar 5 ☐ Other (specify) P.O. 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ ertension in a stag 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy The his certificate h I director, page performed' 2 **⊡**1√0 2 1No 1 ☐ Yes 1 ∐Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completely filled in by the funeral director, p. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certiffer 29c. License number 29d. Date signed (Month, Day, Year)

State

Registrar
DHMH 17 Rev 1/2001

Hanver

South

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

a

3001

32. Registrar's Signatur

Polok

14501

31. Date filed (Month OCT

RESOOI

Street

6,2009

MD 21225

October

Baltimor.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 24a per verb., g896, 10/07/09dhb

Certificate of Death

Reg. No. 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Date C Month Year Physician 21:36 ™ 2009 Warren Malone /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Jown, or Location of Death Examiner Baltimore niversity of Maryland Medical N/A System If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 577-30-7798 DC Director Usual Residence of Decedent 10d. Inside City Limits i show 10a. State 10b. County 10c. City, Town or Location 2 should be filed within 72 hours after death with the Maryla nand Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov raumatic event, Ita Medical Examination at the retitied at 1 Yes 2 No Director Baltimore MD NIA 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1901 Elgi 21217 USAFuneral 12. Was Decedent Ever in U.S. Armed Forces? 1 IP Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 ■ No Specify. 3 Widowed 4 □ Divorced Blac Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Washington Was 18. Mother's Name (First, Middle, Maiden Surname 17. Father's Name (First, Middle, Last) Be Thomas Malone, Sr. IQUIOY Mamie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai Harova, PA 1733/ 20c. Location - City or Town, State Karen c. Mobiley/Daughter 1920 Oak Hills Dr. 20b. Place of Disposition (Name of cemetery, crematory or other place) Pages 1 Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National 10-05-2081 Laurel 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Voughn C. Greene Juneral Six 21. Signature of Funeral Service Licensee auxh · Randallstown, MDZ1133 8728 L -berty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as of ridiac or respiratory arrest shock, or heart similar. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic Brain injur /Medical Due to (or as a consequence of): Examiner Sepsis of Unknown Less then 12 Hours Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) burial-tran and Due to (or as a consequence of): Box 68760 attending physician Physician/Medical as the l IF FEMALE: for use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No Records, P.O. cate has been signed by the page 2 should be detached 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension, Renal Failure, Coronary Artery 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No Recent Small bowd Obstruction 24a. Was an autopsy performed?

Yes 2 \ No certificate Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 124 hours after deaun. le **Funeral Director:** After this robletely filled in by the funeral dir 1 XYes 2 □ No 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) npletely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the To the within 7 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

Registrar

State

6

14474 64 235

Maryland

27/09

2/20

CA-3

Street

32. Registrar's Signature

30. Name and address of person who completed eause of death (Item 23a) (Type, Print)

Greene

South

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar		State of N	naryian	•	artmer r <i>tifica</i> :				-	giene Reg. No.	009	32102
			Decedent's Name (Fin	rst, Middle, Last	)							2. Date of De	eath Day	Year	3. Time of Death
	Physici /Medic		Mary Car	col Mor	se							Septemi		0,2009	8:05 P M
	Examin		4a. Facility Name (If not	institution, give	street and numbe	r)		4b. City	Town, or	Location	of Death	•	4c. C	ounty of Death	
1900 1000 1000 1000	. 6 . 20 . 21 . 22		1802 Prin						Air					rford	
	Funeral		5. Social Security Number	1 45	x 7.7 ]M 2 <b>∑</b> F		last birthday) Yrs.	If Unde Months	r 1 Year Days	If Unde Hours	Min.	8. Date of Bir (Month, Da	ay, Year)	Cou	nplace (State or Foreign untry)
L,	Director		217-60-276	02		56	115.					1/12/	1953	Ma	ryland
	and and		Usual Residence of Dec 10a. State 10b	b. County		10c. City	y, Town or Lo	cation							10d. Inside City Limits
	f sho	ō	MD H	Harford		Be	1 Air								1 ☐Yes 2 🙀 No
	the 128a-	Director	10e. Street and Number					10f. Zi	p Code				10g. Citize	en of What Co	untry?
	with 3a or t be		1802 Prind	Na Driv	<b>1</b> 0				2101	15			ΙŢ	S.A.	
	ms 2:	Funeral	11. Marital Status	TE DIT	12. Was Deceder	nt Ever in U.	.S. 13.	Was Dece			rigin? (Sp	ecify Yes or No Rican, etc.)		1. Race - Amer	
336	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 Is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 3 ☐ Widowed 4 ☐		Armed Forces 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	<b>∂</b> No	1	lf Yes, spe 1 □ Yes				Rican, etc.)	1	Black, White Specify: Wh	ite
	72 hou natura	Completed	15. (Specify o	Decedent's Edu only highest grad	cation le completed)		16a. Deced	dent's Usu kind of w	al Occupa ork done o	ation during mo	st of work	ing	16b. Kind	d of Business/I	ndustry
121	filed within Hygiene. Ither than "	du	Elementary/Secondary	ry (0-12)	College (1-40	r 5+)		lespe					Fur	niture	Retail
d 21	filed Hygid ther snt, tl		17. Father's Name (First	t, Middle, Last)	<u>4</u>		Da	rcop	1.301		ner's Nam	e (First, Middle			
Maryland	2 should be fi and Mental H Is marked ot aumatic ever	To Be	Joseph		L.		Po	wley		Mar	y		J.		Moudry
ary	should band Meni s marked	-	19a. Informant's Name/	/Relationship (7)	pe. Print)		19b. Mailir	ng Addres	s (Street a	and Num	ber or Ru	ral Route Numb	er, City or	Town, State, Z	lip Code)
	1 and 2 Health a tem 27 Is		William D.	Morse,	Sr./Hus					Dri		Bel Air			
ore	0 ·		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cru		Semoval from Sta		Place of Dispo cemetery, crei	sition (Na matory or	me of other plac	e)		Date	20c. Loca	ation - City or	Town, State
altimore,	Pages ment of thant of the ant: If ite ury or of		4 Donation 5			Ana	atany Gi			-		6/2009			Maryland
Balt	permit. Pages 1 a Department of He- Important: If item any injury or othe		21. Signature of Fystera	al Service Licens	ee							atomy G ., Ste.			ry MD 21076
	<u>\$</u>		23a. Part1. Enter the di shock, or heart fai	isease, or comp ilure. List only o	lications that caus ne cause on each	ed the deat	h. Do not ent	er the mo	de of dyin	g, such a	s cardiac	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	ıl	Lu	~		an	ع	\					Onset and Death
7	/Medical Examiner		resulting in death)		Due to (or a	as a conse	uence of):								
		ner	Sequentially list condition if any, leading to immediate. Enter Underlying Cause (Disease of injurity)	ons, diate	b. Due to (or a	as a conseq	uence of):								
	ecuted and transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	y )	C										
68760,	eath certificate be executed attending physician and for use as the burial-transit	a E	is a county and county address		Due to (or a	as a conseq	uence or):								
387	phys phys s the	edical			d										
Box (	certif nding use as	M/S	IF FEMALE: 23b. Was decedent pre	anant	23c. If yes, outcor								23	3d. Date of deli	ivery
B.	death e atter	Physician/M	in the past 12 mon	nths?	1∐Live birth 4∏Pregnant	at time of d		∐Ectopic ן ☐ Other (s		′				Month	Day Year
0	that the de ned by the a detached i	hys	9 □ Unknown	-	9□Unknowr										
S, P	The law requires that the death certi te has been signed by the attending age 2 should be detached for use a	by P	Part II. Other significan	nt conditions co	ntributing to death	but not res	ulting in the u	nderlying	cause give	en in Par	t I.				the cause of death?
ord	w require been sign											1)59	Yes 2	]No 3∏Pr	obably 4 □Unknown
Vital Records,	e law r has be	Completed										24a. Was	ppsy	prior to o	topsy findings available completion of cause of
<u>=</u>		9										perf 1∐ Yes	ormed? 2 X No	death? 1 ☐ Yes	20 No
/ita	nysician: The sister of the certificate director, pag	Be (	25. Was case referred t examiner?								ce of Dea	th (Check only	one)		
or/	Physician; r this certific ral director, I	ို	1 Yes 2 No		Hospital: 1 ☐ Inpa		ER/Outpatier			4 🗆 Г	Nursing H	ome 5 Res			cify)
	ding F	ü.	27. Manner of Death Natural 5	Pending	28a. Date of I (Month, I	njury D <i>ay Year)</i>	28b. Time o Injury		28c. Injur Worl		¬N-	28d. Describe	how injury	occurred	
isic	Attending ir death. ector; After by the fune	icat	2 ☐ Accident 3 ☐ Suicide 6	investigation  Could not be	28e. Place of	iniury - At he	ome farm str	M reet, facto		Yes 2[	7140	28f Location	(Street and	Number or Ru	ıral Route Number,
Division	F 5 F C	Certification:	4  Homicide	determined	building,	etc. (Specif	fy)		, 011100			City or To	wn, State)		rai riodio ridinosi,
	To the Hospital of within 24 hours at To the Funeral D completely filled i	Medical (			rsician: To the be iner: On the basis and manner	of examina									
	To the Ho within 24 To the Fu completed	Me	29b. Signature and title	of certifier				25	3c. Licens	e numbe	1		29d. Date	signed (Mont	h, Day, Year)
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			30) Name and address	of person who c	ompleted cause o	f death (Iten	n 23a) (Type,	Print)	. 1	01		1	<i>~</i>	- 1	1/1 1/2 -1
			eloria	Jimo	nson	M	21116	J-H	igh	. Ot	5	suite	50	20	titon MD 29
	Sta Registi		31. Date filed (Month, D	7 200	32. Hegi	strar's Signa	- Sa	Had	l						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** ,2009 7:16P М 2 October Beulah Rey May /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hamilton 3203 Beverly Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 M 2 X F Days Hours February 22,1917 Maryland Director 92 213-34-4561 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, Ing Medical Examinar must be notified at 1X Yes 2 □ No Hamilton Director Md. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21214 USA 3203 Beverly Road Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No White Specify. ò Specify: 3 ☑ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Sherman Marian F. Newlin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau DTR. 8509 Hanf Avenue Nottingham, Md, 21236 Donna Stevens 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 10-6-2009 Parkville, Md. 4□Donation 5X□Other (SpecifyEntombment | Moreland Memorial 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Schimunek Funeral Home Nottingham, Md. 21236 9705 Belair Road Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner cestive Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine and burial-trar Due to (or as a consequence of) Box 68760. physician The law requires that the death certificate be Physician/Medical the, attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the ad be detached f 1 ☐ Yes 2 🖾 No o 9 Unknown ۵ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed been Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No of Vital Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check onl. one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To : After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 🗌 No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 154 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Da 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1-RANK XAren 940 Bowe.V 31. Date filed (Month, Day, Year) Registrar's Signature 32. State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** Setpember 26, 2009 4:43 Charles Edwin McKeag, III /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Northwest Hospital Randallstown **Baltimore** If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Oct. 5, 19 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** 1 🕱 M 2 🗆 F 85 1923 445-16-8186 Indiana Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 7 is marked other then "naturel", or Items 23a or 28e-f show treumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 X No Maryland Baltimore Owings Mills Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 39 InternationalCircle 21117 USA death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pagas 1 and 2 should ba filad within 72 hours after or nent of Health and Mental Hygiene. Int: If item 27 is marked other then "naturel", or Iter 1 Ma Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married American Baltimore, Maryland 21215-0036 1 Tyes 2 No Specify: ð 3 ☐ Widowed 4 🛣 Divorced Indian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NDT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Sales Manager Tire Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles B. McKeag Sally Manning 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pagas 1 and 2: Department of Health at Important: If item 27 is eny injury or other treu QRCs. Jana McKeag/Daughter 315 Queen Street, Alexandria, Virginia 22314 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Funeral Choices of Chantilly 1 Burial 2 Cremation 3 Removal from State 9/30/2009 \* 4 ☐ Donation 5 ☐ Other (Specify) Chantilly, Virginia 21. Signature of Funeral Sonice Licensee 22. Name and Address of Facility #CC0508 Funeral Choices of Chantilly Wary Roles Downer 14522L Lee Road, Chantilly, Virginia 20151 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Extensive Pneumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions.
Tany, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) P.O. Box 68760 Physician/Medlcal as IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year ģ Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 2 page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed baen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 1 🗌 Yes 2 □ No 1 ☐ Yes 2 X No or Attending Physicien: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 1 ☐ Yes 2X No 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? Injury 1 X Natural 5 Pendina daath. М 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours after To the Funerel Dire To the Hospital 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 26, 2009 H43974 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alice Hsieh Northwest Hospital, 5401 01d Court Road, Randallstown, MD 21133 32 Begistrar's Ignatur State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Physician 12:30 AM VERONICA MCCLEOD OCTOBER 03 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | July 7, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral South Carolina 1 ☐ M 2 🛣 F 231-06-0802 48 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 23a or 28a-f show the Medical Exeminer must be notified at 1X Yes 2 □ No Director Alexandria Fairfax Virginia the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 3204 Pheasant Court 22306 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 'natural", or items 11. Marital Status 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No Specify. à Specify: Black 3 ☐ Widowed 4 No Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than, College (1-4or 5+) 2+ Elementary/Secondary (0-12) Auditor Government permit. Pages 1 and 2 should be filed i Department of Heath and Mental Hygii Important: If item 27 is marked other i any injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John A. McCleod, Sr. Mary L. Henderson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Octavia Pearson 3204 Pheasant Court, Alexandria, VA 22306 (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Mt. Comfort Cemetery 10/12/2009 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Latimore Funeral Services, P.A. 21. Signature of Funeral Service Licensee alruia 9013 Annapolis Road, Lanham MD 20706 alemore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) EPIDERMAL NECROLYSIS **Physician** TOXIC /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Dav 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 🗷 No P.O. the 9 Unknown 9 Unknow signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy performed certificate 2 No 2 No 1 Z Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t 28c. Injury at Work? After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier

Division of Vital Records,

To the the

State Registrar

Medical

29b. Signature and title of certifie

CALVIN DAVID M.D. 5. 31. Date filed (Month, Day, Year) 32. Registrar's Signature

ne and address of person who completed cause of death (Item 23a) (Type, Print)

4940 EASTERNI

and manner stated.

29c. License number

WENUE

RES - 000

BALTIMORE

29d. Date signed (Month, Day, Year)

03.

OCTOBER

MD 21224

2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 935 A M 10 2009 William Walker Morgan /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FRANKLIN Saucre Hospital Center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2□ F Days Director 3/22/1945 64 West Virginia 220-66-0468 Usual Residence of Decedent 10d Inside City Limits 10a. State 10h County 10c. City. Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2√ No Director Maryland Baltimore Rosedale 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 7922 33rd Street 21237 S. A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2 XNo Specify Completed by Specify. 3 Widowed 4 □ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Janitor Restaurant Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Daniel \_Jonas Leatha Lorena Morgan \_Morgan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7922 33rd Street Rosedale, Maryland 21237 Douglas W. Smith (Brother in Law) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 Sn 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final BILaTeral **Physician** Preumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Secondar pneumothorax LEFT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed physician and the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year Day signed by the a 5 ☐ Other (specify) P.O. 1 □Yes 2 □ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by Hypertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has page 2 perform ospital or Attending Physician: The hours after death.

Lineral Director: After this certificate by filled in by the funeral director, pag 1 □ Yes 25. Was case referred to medical examiner?
1 ✓ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated

State Registrar 29b. Signature and title of certifie

31. Date filed (Month, Day, Year)

R

DR Kamlun

21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cuna 900 32. Registrar's Signature

DHMH 17 Rev 1/2001

547

9000 FRANKLIN Square DR

29d. Date signed (Month, Day, Year) 10-5-2009

Baltomd 21237

elissa Rae Mo		State 1- For State Registrar	e of Marylan		rtment of <i>tificate</i> of		and	Mental	l Hyg		eg. No.	20	110	3210
Physicia	an/	1. Decedent's Name (First, Middle,L								Date of Dea Month	Day	Year	1	ne of Death 10 hrs
ledical Exami		Melissa Rae Moody  4a. Facility Name (if not institution, g		er)	41	b. City, Tow	n. or Lo	cation of D		October 3		County of De		101113
		10000 Clarksville Pike		,		Columb					H	oward		
Funeral		5. Social Security Number 6.	Sex 7.	Age (In yrs. la	ast birthday)	If Under 1	Year Days	If Under 2	4Hrs. 8 Min.				Country)	(State or Foreign
Director			M 2X F		20 Yrs.	Months	Days	Tiours	IVIIII.	August	20,1	989		Ohio
any	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City,	Town or Location	on	-					-	10d. I	nside City Limits
<b>*</b>	۲	Maryland Howard Ellicott City 1 Yes 2 X No												
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Coun							ountry?					
th the Maryland 23a or 28a-f sho notified at once.		11650 Masters Run					21042					S.A.		
ath wi	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race - Ar White, et							dian, Black,					
ifter de I", or		3 Widowed 4 Divorc	1 Yes ed If Yes, Give Year or Dates:	2 X No	1 🗆	Yes 2 X	No	specify:			\$	specify: Wh	ite	
hours afte	ed by						16b. Kind of Business/Industry							
36 iin 72 ii. than "	Completed	Elementary/Secondary (0-12)   College (1-4 or 5+)   Early Childhood Institute					<u> </u>	Goddard School						
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	S S	17. Father's Name (First, Middle, La	st)		Inity (ii	<u> </u>	18	.Mother's N	vame (F	irst, Middle,			201001	
1215-0036 Id be filed within 72 Aental Hygiene. varked other than 'event, the Medical	To Be	Dennis Paul Moody						Laurie		. ,				
MD 21 td 2 should Uth and Me m 27 is man aumatic ev		19a. Informant's Name/Relationship Dennis Moody (Fa	(Type, Print) ather)		19b. Mailing							land 21		iode)
		20a. Method of Disposition			Place of Disposit	tion (Name				Date		ocation - City		State
Baltimore, permit. Pages I ar Department of Hec Important: If ite	П	1 X Burial 2 Cremation 4 Donation 5 Other Spec		State	crematory or oth umbia Mem		Park	1	0–10-	-2009	Cla	rksvill	≏ Mar	rvland
taltii rmit. ] spartm rporta jury o		21. Signature of Funeral Service Lice			22. Na	ame and A	dress c	of Facility	Witzl	ke Fune	ral H	omes. I	nc.	
		Male It St	mplinations that equi	and the death	55:	TWI CC	i Kno	olis Ro	ad	Columb	oia, M	aryland	21045	oroximate Interval
Physician /Medical		failure. List only one cause on each line.  Between Onset and												
xaminer		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):												
	_	Sequentially list conditions,												
	Examiner	If any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated												
108 - I		events resulting in death) Last Due to (or as a consequence of):												
e executian and ial - tra	ledical	UNPENDED	AMENDED							_				
760, icate be ex physician the burial	/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, ou					7				. Date of deli	•	
Sox 6876 leath certificate e attending phy for use as the l	sician/M	past 12 months?	months?  4 Pregnant at time of death 5 Other (Specify)							Day	Year			
Boy e death the att	Physi	1 Yes 2 No 9 V Unkno	9 Olikilowi							Tag. 811				F 1 45 O
P.O.	by P	Part II. Other significant condition	s contributing to d	eath but not r	esulting in the u	nderlying c	ause giv	ven in Part	i.					ause of death?
ds, F equires een sign	eted											findings available		
he law require age 2 should by ompleted							perf	autopsy performed? death?  1 ✓ Yes 2 No 1 ✓ Yes 2 No						
tal Recition: The section, page	ပ	25. Was case referred to medical	<u> </u>			26		of Death (C	heck on		2		163	2 110
Vita hysicia this ce	To Be	examiner? 1 ✓ Yes 2 No		atient 2	ER/Outpatient					Home 5		nce 6 🗸 C	ther: Scer	ne
1 of ding Pl After funera		27. Manner of Death  1 Natural 5 Pending	28a. Date of (Month D Oct 2, 200	Injury lay,Year) 19	28b. Time of Ir 2352 hrs	'		at Work?	יחו	8d. Describe river auto		occurred		
isiol Atten r death ector: by the	icati	2 Accident Investigation 28e Place of Injury - At home farm street factory office building etc.							28f. Location (Street and Number or Rural Route Number, City					
Divi	Certification:		Could not be determined (Specify) Major Road / Highway					10	or Town, State) 10000 Clarksville Pike, Columbia, Md.					
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans		20a Cariffer												
To t com	Medical	and manner stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (M.												
		Calno	2/1				O.C.N	I.E.			Octo	ober 3, 20	009	
5		30. Name and address of person who completed c use of death (lt # 23a) *												
			sistant Medical			n Street,	Baltir	more, MI	2120	J1 	-			
St Regist	ate	31. Date filed (Month, Day, 2009	De serve	ou ar a capitlat	ure									

		Please	* *		delible Ink. Ensure artment of Health and	-	_				
	ľ	For State Registrar	State of Maryland	•	tificate of Death		Reg. No. 200	3210			
Physicia /Medica		1. Recedent's Name (First, Middle, Las		My	ers	2. Date of De Month	moer 20 Zear	3. Time of Death 12', 15 M			
	Examiner 4a. Facility Name (If not institution, give street and number)			1	4b. City, Town, or Location of Deat	h V	4c. County of Death				
Funeral	The Johns Hopkins Hospital  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda				Baltimore City						
Director		238-02-0780 1 Usual Residence of Decedent	x <sup>M</sup> 2□F 54	Yrs.	Months Days Hours Min.	1955	NC				
tryland show	_	10a. State 10b. County		y, Town or Lo	cation esville		10d. Inside City Lim				
he Ma 28a-f	Director	MD Baltimore P19						1 ☐ Yes XX No			
ING Z 12 13-0030  be filed within 72 hours after death with the Maryland the Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		9110 Field Road			10f. Zip-Code 21208		10g. Citizen of What Co	SA			
er dea	Funeral	1 XNever Married 2  Married 1  Yes X No If Yes, Give Year or Dates:			Was Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puer	specify Yes or No- to Rican, etc.)	No- 14. Race - American Indian, Black, White, etc.				
ours after	þ				I ☐ Yes 2 📉 No Specify:		Specify: white				
"natu	etec	(Specify only highest grade completed) (Gi			dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	rking	16b. Kind of Business/Industry				
withir than the Me	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			Maintenance		Residential				
ite, INIAI yilaliu ZIZIOUOOO stand 2 should be flied within 72 hours after death with the Marylan af Healith and Memiral Hygiene. the marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be C	17. Father's Name (First, Middle, Last)  Mcrae Myers  18. Mother's Name (First, Middle, Last)  Inez Bri									
i, IVICITYICAL and 2 should ealth and Men n 27 is marke her traumatic		19a. Informant's Name/Relationship (Type. Print)  Roger Myers / Brother  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  9110 Field Rd, Pikesville MD 21208									
permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation <b>3€2</b> 4 ☐ Donation 5 ☐ Other (Specify	Removal from State Bec	emetery crer cks Lut		Date /2009	20c. Location - City of Lexington,	NC			
partition permit. Pages 1 Department of H Important: If ite any Injury or ott		21. Sign ture of Funeral Service Licens	Wictor P. Doda	Jr.22	Name and Address of Facility Charles L. Steven 501 E. Fort Avenu	s Funera	al Home, In	C. 230			
		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death	n. Do not ent	er the mode of dying, such as cardia	c or respiratory a	arrest,	Approximate Interval Between			
Physician		Immediate Cause (Final disease or condition	metasta :	TIL	Sarcoma			Onset and Death			
/Medical Examiner	ĺ	resulting in death)	Due to (or as a consequ		•						
	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequ								
uted ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	C								
be executed cian and burial-transit	ial E	resulting in death) Last	Due to (or as a consequ	uence of):							
g physic as the k			, d		·						
certification of the control of the	Ž/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna		Ectopic pregnancy		23d. Date of delivery				
he death ce the attendii ched for us	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Month	hth Day Year							
s that the hold by the detail	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause										
equire en sig								2 No 3 Probably 4 Unknown			
law re law re las be	Completed					24a. Was auto	osv prior to	utopsy findings available completion of cause of			
The The icate but, pag		25. Was case referred to medical			26 Place of Do		2 No 1 Yes 2 No				
slclar certifi	To Be	25. Was case referred to medical examiner?  1									
ng Phy ter this		27. Manner of Death 1. Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o	f 28c. Injury at Work?	28d. Describe	how injury occurred				
tendir death. for: Af	cati	2 Accident investigation 3 Suicide 6 Could not be		me form etr	M 1 Yes 2 No	Street and Number or I	er or Rural Route Number				
al or At	Certification:	4 Homicide determined	building, etc. (Specify		t, factory, office 28f. Location (Street and Number or Rural Route Number City or Town, State)						
= - 2 = 1	edical (	29a. Certifier (check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
vithir To the	Se l	29b. Signature and title of certifier	11/1	•	29c. License number		29d. Date signed (Mon	th, Day, Year)			
4		- Alle suse	utty un	)	RES-000		septembe	x 68,2004			
\$		30. Name and address of person who	completed cause of death (Item	n 23a) (Type,		North Wo	olfe St, Baltim	ore, MD, 2128			
Stat Registra		31. Date filed (Month, Day, Year)  0 CT 0 7 2009	32. Registrar's Signat	ure fact							
- registia		USA O 1 EGOS	harry la	7							

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Physician/ evin 10 01 2009 7:00p Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 1024 Hartwell Road Baltimore 8. Date of Birth (Month, Day, Year) 09 15 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Days Months 1 🕅 M 2 🗆 F Hours Country) 189-60-5094 Director 45 64 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Examiner must be notified at Director MD NA Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1024 Hartwell Road 21207 U.S.A. items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin any injury or other traumatic event, the Medical Examin Completed by 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes XX No Specify: Specify: 3 Widowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore County Elementary/Seconday (0-12) College (1-4 or 5+) 12th grade Coach School System 4yrs+ Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph McIver Sr. Patricia Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3103 Ferndale Ave, Baltimore, Md 21207 Peggy McIver-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Woodlawn, Md King Memorial Park 10/7/09 22. Name and Address of Facility
March F/H West
4300 Wabash Av 21. Signatur of Ineral Service Ligensee 21215 Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death ardiomy Physician/ opath. disease or condition anter s Medical resulting in death) Due to (or as a consequence of) Examiner dek Sequentially list conditions, if my learning immorphist cause. Enter Underlying Cause (Disease or linjury that initiated events Due to or a consequence of sician and burial-transit Exami the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No ate has been signed by the page 2 should be detached g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗆 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 1 Yes 2 No Yes After this certification funeral director, p 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 1 Yes 2 No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Medical

29a. Certifier

only one)

3

601

MD

32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

🖎 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Baltmore MD

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29c. License number

D00 5

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29d. Date signed (Month, Day, Year)

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Kordell	Muldrow

ordell Muldrow		State of Maryland / Departi 1-For State <i>Certif</i>	ment of He ficate of De			200	5 3211
Physicia		Registrar  1. Decedent's Name (First, Middle,Last)			2. Date of Death		3. Time of Death
ledical Exami	ner			Muldrow	Month September		1152 hrs
		Facility Name (if not institution, give street and number)     University Hospital		ity, Town, or Location altimore	of Death	4c. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last	· · ·		der 24Hrs. 8. Date of Birth		nplace (State or
Director		217-85-5042 X M 2 F  Usual Residence of Decedent	Yrs.	onths Days Hou	rs Min. 08 0	7 09 Foreign	intry) MD
' any		10a. State 10b. County 10c. City, To	own or Location				10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ector		atonsv				1 Yes 2 X No
th the Maryland 23a or 28a-f sho		10e. Street and Number 3719 Flowerton Road	101	Zip Code 21228	10	g. Citizen of What Coun $U \bullet S \bullet A \bullet$	try?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	Frai	11. Marital Status 12. Was Decedent Ever in U.S. 1X Never Married 2 Married Armed Forces?		cedent of Hispanic Or	rigin? ( Specify Yes or No- in, Puerto Rican, etc.)	14. Race - Americ White, etc.	can Indian, Black,
fter dea I", or it	y Fune	3 Widowed 4 Divorced If Yes, Give Year	1 Yes	2 X No specify	y:	Specify: B1	ack
hours a	eted by	( , , , , , , , , , , , , , , , , , , ,	6a. Decedent's U	sual Occupation (Give	e kind of work done	16b. Kind of Business/Ir	ndustry
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examiner	plet	College (1-4 or 5+)   N / A   N / A   N / A   N / A   N / A	N/		,	N/A	
5-00 led wit tygien other	Comple	17. Father's Name (First, Middle, Last)	-		er's Name (First, Middle, M	aiden Surname)	
21215-0036 Juld be filed within 7: Mental Hygiene. marked other than c event, the Medical	Be	Wendell Muldrow  19a. Informant's Name/Relationship (Type, Print )	10h Mailing Adv	The second secon	nice Poole	har City or Tayen State	Zin Codo)
nore, MD 2121 ages 1 and 2 should be fit nt of Health and Mental 1 it: If item 27 is marked other traumatic event,	ပ		3719 F	lowerton	Road, Cat	onsville,	21228
ore, MD ss 1 and 2 sho of Health and If item 27 is her traumati			ice of Disposition matory or other p	(Name of cemetery, lace)	Date	20c. Location - City or	Town, State
Baltimore, permit. Pages 1 an Department of Hee Important: If Itel		4 Donation 5 Other Specify:	On-Site		10/5/09	Baltimor	ce, Md
Balt permit. Departs Import		21. Signature of Funeral Service Licensee	Mar	and Address of Facil Ch F/H W	ëst Ave, Balt	imore. Md	21215
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do failure. List only one cause on each line.	o not enter the m	ode of dying, such as	cardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical kaminer	1	Immediate Cause (Final disease or condition resulting in death)  a Sudden unexplai  Due to (or as a consequence of):	<u>ined dea</u>	th in infa	ancy		Death
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	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated					
led nsit	Exar	events resulting in death) Last  Due to (or as a consequence of):					
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760, ficate be ex g physician the burial	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the		2 DEctor	pic pregnancy	23d. Date of delivery	) Day Year
Box 6876 death certificat the attending ph	iciar	past 12 months?  4 Pregnant at time of death	2 Fetal d  h 5 Other	(Specify)	pic pregnancy	Month	ay rear
O. Bo t the deat by the at ached for	Phys	1 Yes 2 No 9 Unknown g Unknown  Part II. Other significant conditions contributing to death but not resu	ulting in the unde	rlving cause given in l	Part I. 23e, Did tol	bacco use contribute to	the cause of death?
, P.O.	ð			,	1 Yes	[]	ably 4 V Unknown
rds,	ompleted				24a. Was a		topsy findings available ompletion of cause of
Recc The lav	E O			<del></del>	perform		s 2 No
of Vital Records, in Physician: The law requirements the this certificate has been some and director, page 2 should	Bec	25. Was case referred to medical examiner? Hospital:		Othor	th (Check only one)		
of Viing Physican After this Tuneral di	<u>ا</u>	27. Manner of Death 28a. Date of Injury 28	R/Outpatient 3			Residence 6 Other now injury occurred	
ion (tending eath.	ation	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation Fd 9/21/09 F	'd 8:30 a	1 Yes 2	C <sub>No</sub> unk		
Division tall or Attending after death.	Certification	3 Suicide 6 X Could not be determined (Specific) Tesi	ne, farm, street, fa idence	ctory, office building,	etc. 28f. Location (S Baltimo)	street and Number of Ru tate) 3/19 F10 re, MD	ral Route Number, City Werton Rd
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the burial - transition of the funeral director, page 2 should be deached for use as the burial - transition of the funeral director.		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	, death occurred	at the time, date and p	place, and due to the cause	e(s) and manner as state	ed.
To the within To the compl	Medical	one) 2 Medical Examiner: On the basis of examination and/ and manner stated.  29b. Signature and title of certifier	/or investigation,	29c. License numbe		and place, and due to the	
	-	Carol Hall Od -		O.C.M.E.		September 22, 2	
		30. Name and address of person who completed cause of death (item 23	3a)				
UV	ال			et, Baltimore, M	ID 21201		
St Regist	ate rar	31. Date filed (Month, Day, Year) 32. Figistrar's Signature	bare		·		
DHMH 17 Rev 1/2	001	January Ja.	ORIGINAL.				

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 8:34 AM 10 2009 George Neal

4a. Facility Name (If not institution, give street and number) /Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore, MD Baltimore Mercy Medical Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09/04/1964 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours **1√**□ M 2 □ F 219-86-3539 Yrs MD 45 Director Usual Residence of Decedent 10d. inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int If item 27 Is marked other than "natural", or items 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Ever in art. ust be untitled a once. Y☐Yes 2☐No Director Baltimore MD Baltimore 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number 21213 1300 E. Lanvale Street, Apt. 316 USA Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ∐Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ∐Yes 2√∑No Black Specify: Specify: <u>6</u> 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Restaurant Cook 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Hester Lucy Edwards ျှ Robert George Nock 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 502 McCulloh Street, Baltimore,MD 21217 George Shavon Neal/Son
20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10/07/2009 Ardent Cremation Services Hanover, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licensee MOH97 7522 Connelley Drive, Ste. N, Hanover, MD 21076 Zamu CeHardesty 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1 day **Physician** Metabolic acidosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Scools

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed End-Stage reposeduence of) renal sician and burial-trans Division of Vital Records, P.O. Box 68760, the attending physician hed for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 1° ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? After t 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide the Hospital Transparent Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier P24456 10/5/2000 MO/PhD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mercy Medical Kajan Fatemen 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

	Please Type of Print in Black Indelible link. Ensure All Copies Are Legib
For	State of Maryland / Department of Health and Mental Hygiene

			For State		State of Ma	aryland			of Health ar of Death	nd Mental Hy		to the	UY	3 2	114
	_		Registrar  1. Decedent's Name	(First, Middle, La	ast)			imouto		2. Date of De	Reg. No.			3. Time o	of Death
	Physicia		Melvir		William	0	vertor	Ir.		Septem	her	šo,	2009		р. М
4,	/Medic				ve street and number)		VCICOI		n, or Location of		4c.	County	of Death		P
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	Funeral		5. Social Security Nu	umber 6.	Sex 7. Ag	e (In yrs. la	ast birthday)	If Under 1 Y		Hrs. 8. Date of Bi	irth		9. Birthp	lace (State	or Foreign
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	Many	ţo	MD	Prince	Georges	Lau	rel							1 □Ye	s 2 <b>X</b> No
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	ems ems	Funeral Director	11. Marital Status		12. Was Decedent I Armed Forces?	Ever in U.S	S. 13. <sup>1</sup>	Was Deceden	of Hispanic Origin	n? (Specify Yes or N Puerto Rican, etc.)	0-		ce - Americ		
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2	id 2 s lith ar 27 is 27 is 1 trau		Janet L.	·			1	,		. Laurel,				. ′	
<u>ה</u>	f Hear tem		20a. Method of Disp	osition		20b. Pl	ace of Dispo	sition (Name natory or othe	of Contract	ct. Date	20c. Lo	ocation	- City or To	wn, State	
2	ages ent o nt: If I			MCremation 3 [ 5 □ Other (Special)	Removal from State	Ches	apeako	e Crema	tory 2	009	Belt	tsvi	11e,	MD.	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if time 27 is marked other than "natural; or items 23a or 28a-f show any injury or other traumatic event, the Pecifical Examination with be notified a once.		21. Singuran Far	_		.1.	22	2. Name and A	ddress of Facility	Rapp Fune	1		-		rvice
ŏ	any any		P DRS	Dans	M	00982		933 Gis	t Ave. S	ilver Spr	ing,	MD	20910		
			23a. Part 1. Enter th	ne disease, or cor	nplications that caused one cause on each li	the death	. Do not en	er the mode of	f dying, such as ca	ardiac or respiratory	arrest,			Approxima Interval Be	ate etween
4	Physician	i	Immediate Cause (I	Final			ammat	rv Dem	velinati	ng Polyra	dicul	lo N	euron	Onset and	Death
	/Medicai		resulting in death)		Due to (or as			JIJ DC	yciinaci	116 101/14	4104				
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	D .≡	iner	larly, leading to immediate cause. Enter Underlying Cause, Disease or injury												
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r.	ires that the death certif signed by the attending I be detached for use as		Part II. Other signifi	icant conditions	contributing to death b	ut not resu	ilting in the u	nderlying caus	e given in Part I.	23e. Did	tobacco	use con	tribute to th	ne cause of	death?
colds,	Physician: The law requires that the death certif this certificate has been signed by the attending ral director, page 2 should be detached for use as	d by	History	of carci	noma of La	rynx				1 🗆	Yes 2	□ No	3 🗌 Prob	ably 4 🛚	Unknown
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2	il or Attending after death. Director: After d in by the fune	ifica	3 🔲 Suicide	6 Could not determine	28e. Place of Inj	ury - At ho	me, farm, sti	eet, factory, of	fice	28f. Location	(Street a	nd Numi	ber or Rura	l Route Nu	ımber,
5	pital or ours after eral Dire	Certification: T	4 Homicide		building, et	u. (apecny	")			City or 10	own, State	e <i>)</i>			
	ospit hour: unera ly fille		29a. Certifier (Check only	1 Certifying F	Physician: To the best	of my know	wledge, deat	h occurred at	the time, date and	place, and due to the	e cause(s	s) and m	nanner as s	tated.	(e)
	the Hospital or Attendin hin 24 hours after death. the Funeral Director: Af npletely filled in by the fur	ledical	one)	medical EX	and manner st		uon anu/or II	I Cougation, In	my opinion, deatr	1.000dired at the time	o, uate an	J Place,	, and due l	uno cause	(3)

1401

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 7 2009



D0055522

October 1, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** -00 AM 10 0 200 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death County of Death Examiner Baltimore (2004 19 maritan If Under 1 Year | If Under 24 Hrs. Birthplace (State of Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 💢 F 217-26-1679 80 Director 4/15/1929 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a, State 10h. County 10c. City, Town or Location 28a-f show the Medical Expringer must be notified at 1 ☐ Yes 2 ☐ Xo Director MD BALTIMORE PARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō items 23a Funeral 1000 E. JOPPA ROAD APT. 614 21234 within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 ☐ No If Yes, Give Specify Specify: ð 3X Widowed 4 □ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within hand Mental Hygiene.
7 is marked other than " than Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER GOOD SAMARITAN HOSPITAL 12TH GRADE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JOSEPH W. HOLLAND EVE MELVIN 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau JOHN E. O'DONNELL, SR./SON 3508 ROYSTON AVE. BALTIMORE. MD 21206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State MORELAND MEM. PARK 4 ☐ Donation 5 ☐ Other (Specify) 10/8/2009 HILLENDALE. MD 21. Sign vur of Funeral Service Vicensee MO 1 139 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 8521 LOCH RAVEN BLVD. TOWSON. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ocovolle **Physician** disease or condition resulting in death) /Medical s a consequence of) Examiner oromer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ear executed and burial-trar Due to (or as a consequence of) Box 68760. physician the burial pe Physician/Medical The law requires that the death certificate attending p for use as as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.O. signed by the a d be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. þ mona 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has e 2 s autopsy page 2 performe this certificate 2 **X** No 1 ☐ Yes 2 ZNo of Vital 1 □ Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After thi 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 🗆 No within 24 hours after death

To the Funeral Director: completely filled in by the f 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Terrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier and manner stated: 29b. Signature and title of certifu 29d. Date signed (Month; Day, Year) 30. Name and address of pe Raven Boylevard who completed cause of death (Item 23a) (Type, Print) 601

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 Physician abor sharon /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner N/A **Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs Months Davs Hours Min, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) Days 220-74-7374 1959Maryland July Director Usual Residence of Decedent 10c. City, Town or Location 10b. Count ems 23a or 28a-f show must be notified at 10a State Baltimore Maryland N/A Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 21217 2009 Bryant Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Pages 1 and 2 should be filed within 72 hours after 1 Yes 2 No
If Yes, Give Year or Dates: 1 Never Married 2 Married SpeciBlack Baltimore, Maryland 21215-0036 ō 1 Yes 2 No þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working in an NST use of the Profess-16b. Kind of Business/Industry (Specify only highest grade completed) College (1-4 or 5+) Jrban Behavior Elementary/Secondary (0-12) is marked other than 8 vears Associates 18. Mother's Name (First, Middle, Maiden Surnam 17. Father's Name (First, Middle, Last) Be Alfred Bates Carrie Crockett ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a finportant: If item 27 is any injury or other trainonce. Owings Choice Ct. Owings Mills, Maryland 9221 Carrie Saintilme/Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 10/13/09 Donation 5 Other (Specify) Cem. Garrison Owings Mills, Maryland 21. Signature of Foneral Service Licenset 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 ero tarris 23a. Part 1. Enter the sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, slock, or hear ailure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) ician and burial-tran Due to (or as a consequence of): attending physician Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ To the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yes 2 ☐ No Be ၉

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. within 24 hours a

25. Was case referred to medical	26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 X No	Hospital: 1 Inpatient 2 ER/Outpatient 3	□ DOA Other: 4 □ Nursing H	ome 5 ☐ Residence 6 ☐ Other (Specify)					
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation		28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred					
3 Suicide 6 Could not be 4 Homicide determined		ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
	nysician: To the best of my knowledge, death occuminer: On the basis of examination and/or investigated and manner stated.		e, and due to the cause(s) and manner as stated.  urred at the time, date and place, and due to the cause(s)					
29b. Signature and title of certifier		29c. License number	29d. Date signed (Month, Day, Year)					
12002	-	RES-000	october 2,2007					
	completed cause of death (Item 23a) (Type, Print)		North Wolfe St, Baltimore, MD, 2128					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State

Registrar

Certification:

Medical

31. Date filed (Month 32 Registrar's Signature

3. Time of Death

12:53 PM

10d. Inside City Limits

Approximate Interval Between Onset and Death

Day

Year

Yes 2 ☐ No

Barris

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 10-03-2009 **Physician** 7:30A M Edward S. Przybylski, Sr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Upper Chesapeake Medical Center Harford Bel Air If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 05-01-1931 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Country) MD 1**X** M 2□ F 214-26-5789 78 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County if Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, I'm Widol Evan mer out he notified 10a. State 1 ☐ Yes 2X No Director MD Harford Fallston 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21047 2119 Oaklyn Dr Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. Specify: ģ White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) e filed within 7 al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Steel Worker Bethlehem Steel 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be þe Bertha Jasinski Anthony Przybylski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health a Important; If item 27 Is any injury or other trau once. 2119 Oaklyn Drive Fallston, MD 21047 Mary E. Przybylski (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holy Rosary Cemetery 10-06-2009 | Baltimore, MD 4 □ Dg ation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir re of Funeral Service Lice Inc 610 W. MacPhail Rd Bel Air, MD 21014 fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Fart 1. Enter the Immediate Cause (Final Atheroslepotic disease CARdiovascular **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed burial-transi and resulting in death) Last Due to (or as a consequence of): physician a the burial Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy The law requires that the death Month Day Ye ar signed by the at d be detached fo 5 ☐ Other (specify) ∃Yes 2 □No Ö 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Š 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 Mo 1 ☐ Yes 2 No Hospital or Attending Physician: 24 hours after death. neral Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 √No 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA ဥ 28b. Time of 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? 5 Pending investigation 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Under the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

State Registrar 31. Date filed (Month, Day,

venue

NORTH

strar's Signature

BEL AIR MARYLAND 21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Menther 2004 **Physician** 5:31/2M Harry Phillips, III /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 28, 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 X M Maryland 212-40-3919 66 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 ☐ Yes 2 ☐ No Director Florida Brevard Rockledge 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 822 Emerald Way 32955 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2XXNo Specify: ģ Specify. White 3 ☐ Widowed 4XXDivorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Majestic America Elementary/Secondary (0-12) College (1-4or 5+) Line Master Captain 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Patrinicola Harry Phillips, Jr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Gayle Donatell (Daughter) 7356 Eden Brook Drive Apt#712 Columbia, Maryland 21046 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 10/5/2009 Glen Burnie, MD 22. Name and Address of Facility Witzke Funeral Homes, 5555 Twin Knolls Road 21. Signature of Funeral Service Licens Inc. Columbia, Maryland 21045 Approximate Interval Betwe Onset and 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 140cu-die Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy

/Medical **Examiner** 

**Physician** 

Department o Important: If any injury or once,

**Funeral** 

Director

than "natural", or items 23a or 28a-f show he Medical Examiner must be notified at

the

.. Pages 1 and 2 should be filed wi tment of Health and Mental Hygien tant: If item 27 is marked other th jury or other traumatic event, the

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed burial-Division or Vital Records, P.O. Box 68760, physician the attending p ed by the detached

signed to ate has t page 2 s

an/Medical

certificate After Director: hours after within 24 hours aft

To the Funeral D

completely filled in

State Registrar

29b. Signature and tipe of cortifier

the Hospital or Attending

hysici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 □ Pregnant at time of death 5 □ Other (specify) 9 □ Unknown	
ed by Pr	Part II. Other significant conditions	contributing to death but not resulting to the underlying cause given in Part	I. 23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 D No 3 ☐ Probably 4 ☐ Unknown
Complet			24a. Was an autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ☑ No
lo Be	25. Was case referred to medical	26. Plac	e of Death (Check only one)
	examiner? 1 Tes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 N	ursing Home 5 Residence 6 Other (Specify)
ation:	27. Mann → of Death  1 ✓ latural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work?  M 1 □ Yes 2 □	28d. Describe how injury occurred
Certifica	3 ☐ Suicide 6 ☐ Could not lidetermined		28f. Location (Street and Number or Rural Route Number, City or Town, State)
dical		Physician: To the best of my knowledge, death occurred at the time, date a aminer: On the basis of examination and/or investigation, in my opinion, de and manner stated.	

29c. License number

29d. Date signed (Month, Day, Year)

4. pit/ 21218

DHMH 17 Rev 1/2001

ddress of person who completed cause of death (Item 23a) (Type, Print) URSC

32. Registrar' Signat

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** MARGARET 12:40 PM 30 09 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** PG Rine lienesis Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday, 6. Sex **Funeral** Months Days 1 □ M 2 😾 F 454-30-2837 84 Jan 1, Director 1925 Texas Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f showere, the "thought Evander is unit to notified at 1 ☐ Yes 2√ No Director University Park Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6902 Pineway 20782 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 🔀 No Specify: Specify: white 9 3K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygier 7 is marked other th 12 housewife own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဂ J.B. hill Dorothy DeLong 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If item 27 is r any Injury or other traur once. Peter Ripley/son 6902 Pineway University Park, MD 20782 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4∑Donation 5 ☐ Other (Specify) 21. Sign fur of Funeral S, vice Licensee Ronald S. Wadg 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Jirector Baltimore, MD 21201 23a. Pat 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shook, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence or) Examine requires that the death certificate be executed burial-transit and resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 **X**No funeral director 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be 1 ☐ Yes 2 XNo Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred spital or Attending P lours after death. neral Director: After / 1 Natural 2 Accident 5 Pending 1 ☐Yes 2 ☐ No investigation 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours The sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainer as success.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

P.O. Division of Vital Records, Hospital To the Hosp within 24 hou To the Fune completely fi

> State Registrar

Medical

29a, Certifier

(Check only one)

29b. Signature and title of certifier

30. Name and address of person

Eas

who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

4409

29c. License number

D0064208

29d. Date signed (Month, Day, Year)

Riverdale MD 20737

9.30.09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) October 1, Day 2009 Year **Physician** 3:02 p. M Philip Cushman Smith /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Sandy Spring Friends Nursing Home 
 If Under 1 Year
 If Under 24 Hrs.
 8. Date of Birth (Month, Pay, Feb. 11)
 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Year) 1919 Months 1 🔯 M 2 🗆 F Massachusetts 90 034-14-6759 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Midical Event has resilled at 1 ☐ Yes 2 No Brinklow MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20862 19808 Tanbark Way Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ⊠Yes 2 □ No
If Yes, Give WW II 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Never Married 2 X Married Specify: White 1 ☐ Yes 2 👿 No ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Director of Typography Printing permit. Pages 1 and 2 should be filed I Department of Health and Mental Hygii Important: If item 27 is marked other: any injury or other traumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Stevens Philip H. Smith ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19808 Tanbark Way, Brinklow. Maryland 20862 (son) George P. Smith Oct. 7, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland Greek Orthodox Cem. 2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilitRapp Funeral & Cremation Service 933 Gist Ave. Silver Spring, Maryland 20910 21. Signature of Fune a Service Licensee Johns M00982 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Infarction **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. E. t. o. d. flying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine signed by the attending physician and i be detached for use as the burial-trar Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 | No 1 ☐ Yes 1 ☐Yes sompletely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 41 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death after death. Director: After (Month, Day, Year) Injury TX Watural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide thin 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within To the

Division of Vital Records, P.O. SMITH Hospital or Attending Physician:

the Maryland

death with

filed within 72 hours after

Maryland 21215-0036

Baltimore,

5

State Registrar 29b. Signature and title of certifier

Christopher J. Mays, M.D. 18111 Prince Philip Dr. Suite 207 Olney, MD 20832 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

D39793

29d. Date signed (Month, Day, Year)

October 2, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #5 Per FH G897 11/10/09 JH
State of Maryland / Department of Health and Mental Hygiene

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	Physici /Medic		1. Decedent's Name (		Schnitz1	ein					Month / O	Da Da		9 2310	
	Examin		4a. Facility Name (If no	ot institution,	give street and nu	mber)		4b. City	Town, c	or Location of Death	า	40	County of D	ath	
			Franklins	Jangre	- HOSDIT	al Cent	Fer	1	1256	edale			Bat	timor =	-
	Funeral Director		5. Social Security Num 212-22-45	671 91	5. Sex ↓ 1□M 2□F	7. Age (In yrs. 82		Months	Days	If Under 24 Hrs. Hours Min.	8. Date of B (Month, E April	Day, Year	)	Birthplace (State Country) Maryla	_
_	pu: *		Usual Residence of Do	Ob. County		10c Cit	ty, Town o	r Location						10d. Inside C	city Limits
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	r 28%	<u>ie</u>	10e. Street and Numb	er				10f. Zi	Code			10g. C	itizen of What	Country?	
	h wit 23a o st be		4217 So	th Ave	nue					21236			USA		
	deat ms /	Funeral	11. Marital Status		12. Was Dec	edent Ever in U	I.S.	13. Was Dece	dent of F	Hispanic Origin? (S ean, Mexican, Puert	pecify Yes or N	10-	14. Race - A Black, W	merican Indian,	
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland to f Health and Mental Hygiene. It of Health and Mental Hygiene. It filem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 Never Married		d 1 ☐ Yes If Yes, Gi Year or D	2 <b>∏X</b> No ve		1 ☐ Yes			o moun, oton		Specify: W		
	72 hc natu	tec	(Specify	5. Decedent's	Education grade completed)		16a. De	ecedent's Usu	al Occup	pation	rkina	16b. l	Kind of Busine	ss/industry	
Schnitzlein, Shidey Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "I any injury or other traumatic event, the Medone.	Completed by	Elementary/Second		College (	1-4or 5+)		e DO NOT i		during most of wor ed)	Ally	Soc	rial Se	curity A	Admin.
Q d	filed Hyg other ent, t	Ü	17. Father's Name (Fi	irst, Middle, L	ast)					18. Mother's Nan	ne (First, Middi			ourre, i	
<u>a</u> _ <u>r</u>	ld be ental ked c	To Be	Christ	ian H.	Willums	en					Ethel N	Velso	n		
S N	shou nd M mar	-	19a. Informant's Nam	ıe/Relationshi	p (Type. Print)		19b. M	lailing Addres	s (Street	t and Number or Ru	ural Route Num	ber, City	or Town, State	e, Zip Code)	
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± 5	s 1 a		20a. Method of Dispos	sition		20b. I	Place of Di	isposition (Na crematory or	me of other pla	ice)	Date			or Town, State	
\( \)	Page lent nt: If ry or		1 🔀 Burial 2 🔲 4 🗆 Donation 5		3 □Removal from ecify)					theran 10	-6-2009	) No	ttingh	am, Md.	
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V) m	permi Depar Impor any ir		6	11.	111		- 1		97	705 Belai	r Rd. N	Notti	ngham,	Md. 212	236
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	Physician	8 4	Immediate Cause (Findisease or condition		C	ere br	al	Vasc			dent	m	PATINE	Onset and	Death
	/Medical		resulting in death)		Due to	(or as a consec	quence of):		211	1		-	12011	7	
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o.	the a	Physician/M	1 ☐ Yes 2 ☐ I 9 ☐ Unknown		4⊟Preg 9⊟Unkn	nant at time of o	death	5 ☐ Other (s	pecity) _			.			
م.	that the d ed by the detached	윤	Part II. Other signification	ant conditio	ns contributing to d	eath but not res	sulting in th	e underlying	cause giv	ven in Part I.	23e. Dio	tobacco	use contribute	e to the cause of	death?
rds,	w requires that been signed be should be det	ed by									10	] Yes	No 3	Probably 4	]Unknown
် လ	law re as bee	Completed									24a. Wa		24b. Were	autopsy findings	available
æ	The I	E O									pe 1□ Yes	topsy rformed? i 2 <b>x</b> 1N	deati		cause of
<u> </u>	yslclan: The lis certificate hε director, page	Be C	25. Was case referred	d to medical						26. Place of Dea				200 2,20110	
>	Physical this ce	To B	examiner? 1 ☐ Yes 2 No	0	Hospital:	Inpatient 2	]ER/Outpa	atient 3 D	OA Oti	her: 4 Nursing H	lome 5 ☐ Re	sidence	6 ☐Other (S	pecify)	
Division or Vital Records, P.O.	Attending Physician: The law requires that the death certificate be executed refer.  Foreign: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit		27. Manner of Death	5 ☐ Pending investiga		of Injury oth, Day Year)	28b. Tim Inju	ne of iry M	28c. Inju Wo	ıryat ork? ]Yes 2∐No	28d. Describ	e how inj	ury occurred		
isi Sig	or Attencather death Director: in by the	ficat	2 ☐ Accident 3 ☐ Suicide	6 Could no	ot be 28e. Place	of injury - At h	jome, farm				28f. Location	(Street	and Number o	Rural Route Nu	mber,
وَ	Hospital or A 24 hours after Funeral Dire	Certi	4 Homicide	,		ling, etc. (Speci						ōwn, Sta			
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Certification:			xaminer: On the b					time, date and place opinion, death occ					(s)
	To the within 2 To the complet	Σ	29b. Signature and tit	lle of certifier	ny	7-				se number		29d. D	ate signed (M	onth, Day, Year)	
			10	~~(		15			000	29197		10	13/0	1	
10 _			30. Name and address	ae N	ich. A.	<del></del>	Fran	( 5)	Jan .	Drive, I	Baltimi	orr,	MDO	4237	
4	Sta Registi		31. Date filed (Month)	CT 17	2009	eğiştrar's Sign	ature	hard	7			,			

DHMH 17 Rev 1/2001

**ORIGINAL** 

			State of Maryland / Department of Health and M State amend 27 per Dr. g896 107/29 ertificate of Death		giene 0 0	32120
			1. Decedent's Name (First, Middle, Last)	2. Date of De Month	ath Day Year	3. Time of Death
	Physicia		Mark Anthony Spigler, Jr.	01	20 200	9 03:54 M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	ath
À		•	University of Maryland Baltimore		n/a	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Bir (Month, Da	th 9. Bi	rthplace (State or Foreign ountry)
	Director		$n/a$ 1XM $2\square F$ $O$ Yrs. Months Days Hours Min.	1/20/		ryland
	p ,		Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
	aryla shov	<u>_</u>	10a. State 10b. County 10c. City, Town or Location			1 □ Yes 2 No
	8a-f	Director	MD Washington Hagerstown		10g. Citizen of What C	ountry?
	ith the real real real real real real real rea		10e. Street and Number 10f. Zip Code		3	ouridy:
	flied within 72 hours after death with the Maryland Hygiene. Hygiene. that "natural", or items 23a or 28a-f show ent, the Moteral Evertilies in set to notified at	Funeral	10011 Beaver Creek Church Road 21740	a situ Va a av Na	USA 14. Race - Am	arican Indian
	item:	Š	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whi	
36	, or	by F	1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 ☑ No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:		Specify:	White
8	hour tural	ba l	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of Business	
5	n 72 n "na n "na	Completed	(Specify only highest grade completed) (Give kind of work done during most of work	ing		
12	withi	E C	Elementary/Secondary (0-12) College (1-4or 5+)		n/a	
0	filed Hygi sther ent,		- V	e (First, Middle	, Maiden Surname)	
a	d be ental ked c	To Be	Mark Anthony Spigler, Sr. Tanya	Lynn W	e1ch	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Marylan of Health and Mental Hygiene. If Health and Mental Hygiene is the first standard other than "natural", or items 23a or 28a-f show other traumatic event, the "Medical Eventions" must be notified at	-	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rur			Zip Code)
	and 2:		Mark Anthony Spigler, Sr. 10011 Beaver Creek Chu	rch Rd.	Hagerstown	n, Md. 21740
<u>6</u>	s 1 and 2 f Health item 27 i		TIGHT THE TIME OF TIME OF THE TIME OF TIME OF THE TIME OF TIME OF THE TIME OF TIME OF THE TIME OF TIME OF THE TIME OF TIME OF THE TIME OF	Date	20c. Location - City of	
5	Pages nent of ant: If ite ary or o		1 Li Bunai 2 A Cremation 3 Li Hemovai from State	3/09	Baltimore	maryland
Baltimore,	permit. Pages Department of Important; If ii any injury or once.				rk Funeral	The second of th
Ba	permit. Departr Imports any inju	9 9	3620 Wilkens Ave.			
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause in each line.			Approximate Interval Between
is .		6 17	Immediate Cause (Final			Onset and Death
1	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):			
1	Examiner		Due to (or as a consequence of).			
		e e	Sequentially list conditions, if any learning to immediate			
	uted I Insit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	ernia		
	exection and all-tra	Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):			
8760,	icate be executed physician and s the burial-transit	dical I	d			
89	ificati g phy is the	edic	V.		- 1	
č	leath certific attending p	₹.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of d	elivery
Division of Vital Records, P.O. Box	death a atte	Physician/Me	in the past 12 months?  4 Pregnant at time of death 5 Other (specify)		Month	Day Year
O I	at the de by the tached	hys	9 Unknown			
	that ned by deta	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did	tobacco use contribute	to the cause of death?
ğ	quires n sig ald be	q p		1 🗆	Yes 2 ☐ No 3 ☐	Probably 4 ☐ Unknown
8	w requires that s been signed b should be deta	Completed		24a. Was	an 24b. Were	autopsy findings available
8	he law e has ige 2 t	mc			ormed? death	completion of cause of
ā	in; T ifficat or, pa		25. Was case referred to medical 26. Place of Dea	1 □ Yes		es 2 No
>	Physician; The la r this certificate had ral director, page 2	Be c	examiner? Other:		idence 6 ☐ Other (S)	pecify)
ō	ttending Phy death. :tor: After this the funeral c	Ë	27, Mapner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		how injury occurred	
<u></u>	th: Afte	텵	1 Matural 5 □ Pending (Month, Day, Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 □ No			
<u>s</u>	Atter	lj Ce	3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office	28f. Location	(Street and Number or	Rural Route Number,
á	after after din t	Certification: To	4 ☐ Homicide determined building, etc. (Specify)	City of 10	iwn, State)	
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  Within 24 hours after death.  Sompletely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 17 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place	, and due to the	e cause(s) and manner	as stated.
	le Ho	Medical	(Check only a Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence) and manner stated.	rred at the time	, date and place, and d	ue to the cause(s)
	To the To the Comp.	ĭ	29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
			Umm ID # 1903	38	1/20/200	9
			(1.11/10-20) (7.12/10)			- STATE OF THE PARTY OF THE PAR
		1	30. Name an indices of person who completed cause of death (term 23a) (type, Print)  Shakequa Dasnadi, 29 South Grene St, Room & Slica	, Bal	etimore, M	10 21201
Ė	Sta	te	31. Date filed (Month, Day, Year) 22. Registrar's Signature	/		
	Registr	ar	QCT U7 ZUUS Sharma for for forman			

DHMH 17 Rev 1/2001

		•	1 - For State Registrar		Ce	rtificate of	Death	Reg	g. No.	06161
			1. Decedent's Name (First, Middle	, Last)				Date of Death    Month	Day Year	3. Time of Death
	Physici /Medio		Robert	Paul Sch	nreiber			10	4 09	410 AM
The state of the s	Examin		4a. Facility Name (If not institution	give street and number,	)	4b. City, Town, o	r Location of Death		4c. County of Dea	
, i			Franklin Sauar	e Hospital		Roseda			Baltmon	
	Funeral		5. Social Security Number		ge (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Bit	thplace (State or Foreign ountry)
	Director		217 54 2974	¹√ M 2□ F	59 Yrs.	1		06/06/19	50 Mar	yland
	pu:		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	nestion				10d. Inside City Limits
	shov	-	Tob. County		Toc. City, Town of Ed	ocation				1 ☐Yes 2∏No
	8a-f	Sct	Maryland Baltim	ore	Essex					
	ith th	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What C	
	s 23a	<u>ra</u>	631 Rockaway Be				1221			USA
	72 hours after death with the Maryland 'natural', or Items 23a or 28a-f show deal Examinast be noffiled at	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S. 13.	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (Spe an, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Whit	
36	or i	by F	1 Never Married 2 Marri	If Vac Give	No	1 □Yes 2 No	Specify:		Specify:	192
00	ural'	d b	3 Widowed 4 Divorced		1970–76	death Havel Ossu	nation.	Ti-	6b. Kind of Business	nite
21215-0036	"nat	Completed	15. Decedent (Specify only highes	t grade completed)	(Give	edent's Usual Occup  kind of work done  OO NOT use retire	during most of workin d)	ng i'	ob. Kind of Business	industry
12	within iene. than "		Elementary/Secondary (0-12)	College (1-4or	5+)				Collec	
	filed Hygi Sther ent, II		17. Father's Name (First, Middle, L	ast)	SI	actonary	Engineer  18. Mother's Name	(First, Middle, Ma		Е
au	lbe fintal ed o	Be	Albert C. Schre				Dorot		_ `	
Ĕ	should and Mer s marke umatic	٩	19a. Informant's Name/Relationsh		405 Mail	ine Address (Chroni	t and Number or Rura			Zin Cada)
Maryland	d 2 sl th an 7 is r traur		Dorothy Schreib							ryland 2122°
	1 and Health em 27 ther tu		20a. Method of Disposition		20b. Place of Disp				0c. Location - City or	
ō	ges it of l		N Burial 2 ☐ Cremation	3 Removal from State	cemetery, cre	matory or other pla	ce)		-	
ţi	t. Pa tmer tant		4 Donation 5 □ Other (Sp	necify)	Gardens d		Cem. 10/7/		altimore,	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Machael Exprehengment at the Indianal and once.		21. Sign vure vi r vineral Service L	ice see			ess of Facility Bru			
_	_ = a o		M D	7			Eastern Av			
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that cause only one cause on each I	d the death. Do not en ine.	ter the mode of dyi	ing, such as cardiac o	r respiratory arres	st,	Approximate Interval Between
4	Physician	i V	Immediate ause (Final disease or condition	- Pheuma	mia.					Onset and Death Un Known
	/Medical		resulting in death)		a consequence of):					0.00
	Examiner		Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Cause). The cause (Disease or injury Cause). The cause (Disease or injury Cause). The cause (Disease or injury Cause).							VNKnown
	D #	ner								
	cutec nd ransi	Examiner	Cause (Disease or injury that initiated events	· MRSOTI	nelioma					
oʻ	icate be executed physician and the burial-transit	Ä	resulting in death) Last	Due to (or as	a consequence of):					
68760,	ysici ysici e bu	Medical	1	d						
68	ertifica ling ph e as th	edi		1					1	
Вох	eath cer attendin for use		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		Ectopic pregnan			23d. Date of de	elivery
m.	deatl e atte d for	Physician/	in the past 12 months? 1 □Yes 2 □ No	4 Pregnant		☐ Ectopic pregnant ☐ Other <i>(specify)</i> _	су		Month	Day Year
P.0	at the de by the tached	hys	9 Unknown	9 Unknown						
, T	ires that signed I	by P	Part II. Other significant condition	ns contributing to death I	but not resulting in the u	underlying cause gi	ven in Part I.	23e. Did toba	acco use contribute	to the cause of death?
g	quire; n sig ald bu	d b						1 ☐ Yes	s 2 □ No 3 □ F	Probably 4 🗹 Unknown
00	w requir s been s should I	Completed						24a. Was an	24b. Were a	autopsy findings available completion of cause of
Re	he la e ha: ge 2	Ę.				· · · · · · · · · · · · · · · · · · ·		autopsy perform	ed? death?	
a	n; T ificat xr, pa		25. Was case referred to medical				00 Di ( D II	1 ☑ Yes 2		s 2 PŃo
Ξ	stcia cert recto	Be	examiner?  1 Yes 2 No	Hospital:		Otl	26. Place of Death her: 4 ☐ Nursing Hor	·		· · ·
Division of Vital Records,	Phy r this ral d	Certification: To	27. Manmer of Death	28a. Date of Ini	ient 2 ER/Outpatie			ne 5 ∟ Hesider 28d. Describe hov		вспу)
O	ding h. Afte fune	io	1 ☑ Natural 5 ☐ Pending	(Month, D	ay, Year) Injury	of 28c. Inju Wo M 1 [	rk? ]Yes 2 □No			
S	deatl ctor: / the	ica	3 ☐ Suicide 6 ☐ Could n	ot be 280 Place of In	jury - At home, farm, st			P8f. Location (Str.	eet and Number or F	Bural Boute Number.
≥	or A after Direct in by	i i	4 ☐ Homicide determi	ned building, e	tc. (Specify)	rect, lactory, omec		City or Town,	State)	Total Floats Floating
7	pital ours a eral filled		29a. Certifier 1 - Certifyin	g Physician: To the best	t of my knowledge, dea	th occurred at the t	time, data and place	and due to the ca	ause(s) and manner	as stated
	Hos 24 ho Fun tely	ica		Examiner: On the basis	of examination and/or i	nvestigation, in my	opinion, death occurr	ed at the time, da	ate and place, and du	ie to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death.  Within 24 bours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29b Signature and title of certifier	and manner s		29c. Licen	se number	29	d. Date signed (Mor	nth, Day, Year)
	5 1 × 5		Los, orginature and the or certifier	The Hours	sil mi	) 7	69100	/	OCTUBER	3,4,2000
	con and		June	7-6-7			01/10	1000	47	, , , , , ,
	121		30. Name and address of person of the state	who completed cause of	death (Item 23a) (Type	, Print) JOH	1-1	4524	0=	
	, v. v		1000 FAT	Loo Deste	tror's Signature	1/2/2	E, 34	- 72ma	OPIZ	
	Sta	te	31. Date filed (Month, Day, Year)	poz. Hegist	trar's Signature					

Registrar

OCT 0 7 2009

Schreiber, Dobert

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Dep : tment of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Alfred J. Sylvester 16, 2009 6:40 PM September /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Charlotte Hall Veterans Home St. Mary's Charlotte Hall Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 □ F 21, 97 1911 Dec Delaware 577**-**05-7809 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show unt; of their training the count, Ir. Modice Exa is an interest or with the count. 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 1 ☐ Yes 2√ No MD St. Mary's Director Charlotte Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 29449 Charlotte Hall Road 20622 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ∑Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐Yes 21 No Specify: Specify: white Be Completed by 3 Widowed 4 □ Divorced 1943 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) service stations manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James Sylvester Lucy Richie ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Steele/granddaughter 21035 1518 Patuxent Manor Road Davidsonville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition permit. Page:
Department o
Important: If |
any Injury or 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) Signature of Euneral Service Licer Ronald S 22. Name and Address of Facility Wade State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Par 1. Enter the disease, or cour lich in as that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sho k, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat a use (Final disease or condition resulting in death) **Physician** HIZheimers /Medical Due to (or as a consequence of): Examiner CHF Sequentially list conditions, if any, leading to immediate Medical Examiner Due to (or as a consequence of) cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last CKD Stage attending physician and for use as the burial-trar Due to (or as a consequence of): Amal IF FEMALE: s been signed by the should be detached page certificate After this certific funeral director,

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

Baltimore, Maryland 21215-0036

ıysıcıan/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregnancy  1   Live birth 2   Fetal death 4   Pregnant at time of death 9   Unknown  3   Ectopic pregnancy 5   Other (specify)	23d. Date of delivery  Month Day Year
ed by Pr	Part II. Other significant conditions of	ontributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown
omplet			24a. Was an autopsy autopsy performed? 1 □Yes 2 ☒No 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 ☒No
به	25. Was case referred to medical	26. Place of Death (C	heck only one)
0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home	5 Residence 6 Other (Specify)
ation: I	27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?  M 1 □ Yes 2 □ No	. Describe how injury occurred
Sertific	3 Suicide 6 Could not b 4 Homicide determined		Location (Street and Number or Rural Route Number, City or Town, State)
alcal (	29a. Certifier 1 CertifyIng Pr (Check only one) 2 Medical Exar	nysician: To the best of my knowledge, death occurred at the time, date and place, and niner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	due to the cause(s) and manner as stated.  at the time, date and place, and due to the cause(s)

29c. License number

D67814

CHARLOTTE HALL

29d. Date signed (Month, Day, Year)

mD

20622

State Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT

BRUNEY

07

FRANCISCA

MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29449

32/Registrar's Signature

arke

CHARLOTTE HALL RD

Smith

7. Age (In vrs. last birthday)

10c. City, Town or Location

Certificate of Death

4b. City, Town, or Location of Death

21144

Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. (Month, Day,

Hours

Severn

Days

Severn

1 ☐ Yes 2 🖫 No Specify:

Electronic Assemblyman

(Give kind of work done during most of working life. DO NOT use retired)

10f. Zip Code

16a. Decedent's Usual Occupation

Months

3. Time of Death

Ρм

7:45

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 □Yes 2 No

Rea. No

October 04, 2009

4c. County of Death

10g. Citizen of What Country?

United States

Specify:

16b. Kind of Business/Industry

Defense Company

14. Race - American Indian

White

Black, White, etc.

Anne Arundel

Indiana

2. Date of Death

04-05-1959

Director

Funeral

þ

**Examiner** 

**Funeral** 

Director

James

5. Social Security Number

10e. Street and Number

11. Marital Status

10a. State

MD

220-80-8849

Usual Residence of Decedent

1355 Monaco Drive

1355 Monaco Drive

1 ☐ Never Married 2 ☐ Married

3 Widowed 4 Divorced

Elementary/Secondary (0-12)

12

Anthony

12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates:

College (1-4or 5+)

4a. Facility Name (If not institution, give street and number)

10h County

Anne Arundel

15. Decedent's Education (Specify only highest grade completed)

Completed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl G. Smith Helen Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathy Smith - Wife 1355 Monaco Dr., Severn, Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 10-09-09 Meadowridge Mem Pk. Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gary L. Kaufman Funeral Home, 21. Signature of Funeral Service Licensee 7250 Washington Blvd., Elkridge, Maryland 21075 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Mellitus bel reen /Medical Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Unionying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 2 1 No 3 Ectopic pregnancy Year Month Day 1 ☐ Yes 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 1 No 1 ☐Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \sum \) Nursing Home 1∐Yes 2MNo 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation within 24 hours after deaun.

To the Funeral Director: Af 1 ☐ Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nest Edget MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 1/2001 **ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OLTUBER Day **Physician** = 17859 7:13F MILDRED MAY STAGGE /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death Examiner Towson Center Saint Joseph Medical If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 6. Sex Months Days Hours 1 M 2 K 212-22-3514 Director 84 2/21/1925 MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d Inside City Limits r 28a-f sh 1 TYes 2 No Director MD BALTIMORE TOWSON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? s 23a or 119 B VERSAILLES CIRCLE Funeral 21204 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. other traumatic event, the Medical Exaliging to Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 ò 1 □Yes 2 No If Yes, Give Year or Dates: ģ Specify: Specify: WHTTE 3 Widowed 4 □ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) CALVERT HALL SECRETARY 12TH GRADE other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be h and Mental h GUY SMITH RUTH SHATZER ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau NANCY M. STAGGE/DAUGHTER 88 ENGLISH RUN CIRCLE SPARKS, MD20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) METRO CREMATORY, INC. 10/5/2009 CATONSVILLE, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. MO1139 eath Ha 8521 LOCH RAVEN BLVD. TOWSON, 21286 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death YEARS Immediate Cause (Final Physician RIGHT HEART FAILURE resulting in death) /Medical Due to (or as a consequence of) Examiner 5 YEARS BILATERAL PLEURAL EFFUSIONS Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): YEARS TRAPPED LUNGS and resulting in death) Last physician al s the burial-t Due to (or as a consequence of) Box 68760, Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 the past 12 menths? Month Day Year signed by the a 5 Other (specify) o 9 Unknown o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Division of Vital 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 27. Manner of Death After t 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 XNatural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and Alle of certifier 29d. Date signed (Month, Day, Year) 29c. License number D 25886 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 21204 7601 OSLER DRIVE. 31. Date filed (Month, Day, Year) TOWSON. D. M . Registrar's Signature State OCT 0 7 2009 Registrar

Physician   Medical   Michael   Medical   Michael   Medical   Me	
Helen Michelle Shanks   Accomposition   Acco	. Time of Death
Examiner    A. Facility Name (If not institution, give street and number)   Ab. City, Town, or Location of Death   Ac County of Death	0:00 A
Bright Gardens of Tuckerman  Bethesda  Montgomery  S. Social Security Number  5. Social Security Number  6. Sex  70 77-30-5346  10 M 20 F 7 Age (In yrs. last birthday)  70 Yrs. Months  Days Hours  Months  Days Hours  Month  Bethesda  Montgomery  9. Britplace  (Months, Day, Year)  (	*
Social Security Number   Social Security Num	7
Director    107-30-5346   1	(State or Fore
Usual Residence of Decedent 10a. State   10b. County   10c. City, Town or Location   10d.   1	
Elementary/Secondary (0-12) 12 12 13. Mother's Name (First, Middle, Maiden Sumame) 15. Teacher 16. Do Not use retiried by 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zip Co 19. Mailling Address (Street and Number or Rural Route Number, City or Town, Consense or Conditions) 10. M	
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Anatomy Gifts Registry   10/5/2009   Hanover, Mary Gifts Registry	
Anatomy Gifts Registry   10/5/2009   Hanover, Mary Gifts Registry	
Anatomy Gifts Registry   10/5/2009   Hanover, Mary Gifts Registry   10/5/2009   Hanover, Mary Gifts Registry   10/5/2009   Hanover, Mary Gifts Registry   21. Signature of Funeral Service Licensee   22. Name and Address of Facility Anatomy Gifts Registry   7522 Connelley Dr., Ste.P., Hanover, MD	
1   Burial 2   Cremation 3   Removal from State	Reiman
1   Burial 2   Cremation 3   Removal from State	de)
1   Burial 2   Cremation 3   Removal from State	
1   Burial 2   Cremation 3   Removal from State	
21. Signature of Funeral Service Licensee  22. Name and Address of Facility Anatomy Gifts Registry  7522 Connelley Dr., Ste.P, Hanover, MD  23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in Shock, or heart failure. List only one cause on each line.  Physician (Medical Examiner)  Medical Examiner  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Breast Cancer  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	y Land
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Breast Cancer  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):	01076
shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Examiner  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):  Due to (or as a consequence of):	21076
f any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	
The purpose of the pu	ay Year
Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the conditions contribute to the conditions.	
24a. Was an autopsy performed? death?  1	2
24a. Was an autopsy prior to comp death?	etion of cause
	□ No
1   Yes 2 X No   1   Yes 2 (	
y v o l l l res 2 l x No l l l Inpatient 2 l EH/Outpatient 3 l DOA l L X Nursing Home 5 l Hesidence 6 l Other (Specify)	
27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Injury Work?	
1 XNatural 5 Pending (Month, Day Year) Injury Work?  1 XNatural 5 Pending (Month, Day Year) Injury Work?  2 Accident investigation 5 City or Town, State)	
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?  1 Solution 2 Could not be determined 28c. Place of Injury - At home, farm, street, factory, office 28c. Cartifier (Check only one) 28c. Cartifier 29c. Cartifier 29c. Check only one) 28c. Cartifier 29c. Cartifier 29	Route Number,
2   Accident   3   Suicide   4   Homicide   28e. Place of Injury - At home, farm, street, factory, office   28f. Location (Street and Number or Rural Fig. 1)   29e. Cartifor   29e. Cartifor	ed ne cause(s)
one) and manner stated.  29c. License number 29d. Date signed (Month, Date signed (Month, Date signed (Month), Dat	
290. Signature and title of definition D33357 10/1/09	y, Year)
D33357 10/1/09	y, Year)
30. Name and adult is of person who completed cause of death (Item 23a) (Type, Print)	ay, Year)
Lee Jonathan Musher M.D. 5530 Wisconsin Ave. Chevy Chase, MD 20815	iy, Year)
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature 1. Senistrar	iy, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death SEPT. 28°, 2009° Physician/ 12:15 PM SWIGER Medical a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Anne Arundel North Arundel Health and Rehab. Glen Burnie 8. Date of Birth Social Security Number Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Hours Days 1 □ M 2X F 0572471918 West<sup>y)</sup>Virginia 91 219-30-5125 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State Director 1 Yes 2 XNo MD Glen Burnie Anne Arundel 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral United States 313 Hospital Drive 21060 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12, Was Decedent Ever in U.S Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3X Widowed 4 ☐ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Homemaker Own Home Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Willa Gertrude Shaw Asberry Creed Chriship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 719 214th Street, Pasadena, MD 21122 Donald Swiger , Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wallace Lions Cemetery 10/03/2009 Wallace, West Virginia 20a. Method of Disposition 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Dorsey Funeral Home Signature of Fundral Service Licensee T. Harman 701 Pike Street, Shinnston, WV 26431 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Se uentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural work' 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 24 hours after death 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number September 28, 2009 D-40521 DRIVE, SMITE 208 HOSFITAL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 325 DR OCHANE STEN BENRNIE, MD 2106

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

	1 - For State Registrar	State of Maryland	I / Department of I Certificate of		ental Hygiene Reg. No	2000	3212
Physician /Medical	1. Decedent's Name (First, Middle, LEANNE XUAN				2. Date of Death Month Da ptember	27 Žear 0 9	3. Time of Death 8:48 am
Examiner	4a. Facility Name (If not institution, Greater Balti	nive street and number) more Medical	Center Town, o	r Location of Death S O N	4c	County of Death Baltimon	re
Funeral Director	5. Social Security Number 6	Sex 7. Age (In yrs. la	st birthday) If Under 1 Year Yrs. Months Days	If Under 24 Hrs. 8 Hours Min.	3. Date of Birth (Month, Day, Year)		ce (State or Foreign ) ] and
tited within 72 hours after death with the Maryland wher then "natural", or items 23a or 28a-f show ant, its Motical Evanithm must be notified at e Completed by Funeral Director	Usual Residence of Decedent  10a. State 10b. County  Maryland Balt		Town or Location herville-Ti	monium			. Inside City Limits 1 ☐ Yes 2 ☐ No
h with the Mar 23a or 28a-f s st oe notified al Director	10e. Street and Number 110 ARDOON R		10f. Zip Code	093		tizen of What Country	?
in removes and occur will be wayna e an "natural", or items 23a or 28a-f show Medical Eva., irmt is ust be notified at apleted by Funeral Director	11. Marital Status  1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.S. Armed Forces?			ify Yes or No- ican, etc.)	14. Race - American Black, White, etc. Specify: GJH	
ygiene. er than "natural t, tr. M.dical E.	15. Decedent's (Specify only highest the Elementary/Secondary (0-12)	Education brade completed)  College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire.	oation during most of working d)	16b. K	(ind of Business/Indus	
d out	N/A 17. Father's Name (First, Middle, La	N/A	N/A		First, Middle, Maider		
ls marke aumatic	VIEN THAI  19a. Informant's Name/Relationship	(Type. Print)	19b. Mailing Address (Street	MELISS and Number or Rural		THAI or Town, State, Zip Co	ode)
int: If item 27	Greater Baltimor  20a. Method of Disposition  1□ Burial 2□ Cremation 3  4□ Donation 5 ₩ Other (Spe	20b. Pla	6701 N. Char ace of Disposition (Name of metery, crematory or other plan			e, MD 21204 ocation - City or Town	
Important: If it any injury or once.	21. Signature of Funeral Service Lic RODALD S	ensee Director	22. Name and Addre State Anat Baltimore,	omy Board	655 W. Bal	ltimore St	reet
sician ledical	23a. Pa 1. Enter the dilease, in c shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	inplications that caused the death. y one cause on each line.  a.  Due to (or as a conseque	Do not enter the mode of dyin	ng, such as cardiac or	respiratory arrest,	A) In O	pproximate iterval Between inset and Death
physician and the burial-transit and the burial-transit and the burial Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b					
g physicials the burner at the		d	•				
for use a	IF FEMALE: 23b. Was decedent pregnant be past 12 months? 1 □Yes 2 ☑No 9 □ Unknown	23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal of 4 ☐ Pregnant at time of dea 9 ☐ Unknown	leath 3 Ectopic pregnance	у		23d. Date of delivery Month Da	ay Year
an signed uld be det	Part II. Other significant conditions	contributing to death but not result	ing in the underlying cause giv	en in Part I.		use contribute to the o	cause of death? ly 4 🗌 Unknown
To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached Medical Certification: To Be Completed by Physic				·	24a. Was an autopsy performed?	death?	letion of cause of
ector, Be	25. Was case referred to medical examiner?	Llagritati	law	26. Place of Death (	Check only one)		
ral dir	1 ☐ Yes 2 ☐ No 27. Manner of Death	**	R/Outpatient 3 DOA Oth	4 LI Nursing Home		6 ☐ Other (Specify)	
To the Funeral Director: After this certific completely filled in by the funeral director, I Medical Certification: To Be C	1 Natural 5 Pending 2 Accident investigati 3 Suicide 6 Could not	(Month, Day, Year)	Injury Wor M 1 □	Yes 2 □No	d. Describe how inju	•	
ral Direc	4 Homicide determine	building, etc. (Specify)			City or Town, State		
ompletely fil	(Check only 2 Medical Ex	Physician: To the best of my knowl aminer: On the basis of examination and manner stated.	on and/or investigation, in my o	ppinion, death occurred	at the time, date an	d place, and due to th	ne cause(s)
S Co	29b. Signature and title of certifier	SUM NO	29c. Licens	e number 501327	29d. Da	ate signed (Month, Da)	y, Year)
#	30. Name and address of person wh	eau, M.D., 6569		St Baltin	ore.MD	21204	
State	31. Date filed (Month, Day, Year)	32. Fegistrar's Signatur					

DHMH 17 Rev 1/2001

09-07605 Davon Tucker

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

As Facility Name (if not institution, give street and number)  4a. Facility Name (if not institution, give street and number)  4boths Holphish Holphish  5boths Holphish  5boths Holphish  5boths Holphish  6county of Death  4c. County of Deat	2009 3212	Reg. No.	ate of Death	Certific	I- For State Registrar						
Solution Residence of Decement    Tools line   Tools		Month Day Year September 30, 2009	Ker	Davon Tuc	Decedent's Name (First, Middle, Last)						
Director    1	NA			street and number)	•						
10c. City, Town or Location   10d. Inside City   1/2 to 2   2 to 3   10g. Citzen and Number   10d. Inside City   1/2 to 2 to 3   10g. Citzen and Number   10d. Inside City   1/2 to 2   10d. City	Foreign	Months Days Hours Min.									
The series of t	10d. Inside City Limits 1 Yes 2 No		Battinar 10f. Zip Code	4	10a. State 10b. County Maryland N		ж алу				
Amendate Cause (Final disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Physician   Physici	Vhite, etc. Black	of work done 16b. Kind of Busi	If Yes, specify Cuban, Mexican, I  1 Yes 2 No specify:  Decedent's Usual Occupation (Give ki	12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Datas: y highest grade completed) 16	11. Marital Status 1 Never Married 2 Married 3 Wildowed 4 Divorced 15. Decedent's Education (Specify on	by Funeral	irs after death w ural", or items				
20a. Method of Disposition  20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, Date 2cc. Location - City of Town, State 2cc. Location - City of Town, St	N/A- ame)	ame (First, Middle, Maiden Surname)	N/A 18.Mother's	College (1-4 or 5+)	0	Complete	-0036 d within 72 P ggiene. ther than "r				
Amendate Cause (Final disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.    Physician   Physici		or Rural Route Number, City or Town	b. Mailing Address (Street and Numb		Rodney Parker  19a. Informant's Name/Relationship (T)	Be	21215 hould be file id Mental Hy is marked o				
Physician M dical xaminer    23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.   Immediate Cause (Final disease or condition resulting in death)   Due to (or as a consequence of):	tion - City or Town, State	Date 20c. Location - Catonsv	of Disposition (Name of cemetery, tory or other place)	Removal from State 20b. Plac	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other Specify:		es I and 2 of Health If item 2				
failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death)  Late of the late of th		Ave Baltimore	3512 Frederick	Jaken	Kevin		Balt permit Depart Impor injury				
The part of the pa	failure. List only one cause on each line.  Immediate Cause (Final disease a <u>Sudden unexplained death in infancy</u> Between Onset and Death  Death										
AMENDED  AME					if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	xaminer	d sit				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death of		23d. Date of	2 Fetal death 3 Ectopic	23c. If yes, outcome of pregnan  Live birth  Pregnant at time of death	X UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	sician/Medical	' <b>60,</b> ate be exphysician				
24a. Was an autopsy findings prior to completion of code ath?  1 V Yes 2 No 1 V Yes 2			ng in the underlying cause given in Pa		Part II. Other significant conditions	by Phy	P.O. es that the igned by				
	<ul> <li>24b. Were autopsy findings available prior to completion of cause of death?</li> <li>1  No</li> <li>No</li> </ul>	autopsy pperformed? d				omplete	Records The law requirected that the law requirected has been a page 2 should				
25. Was case referred to medical examiner? 1 Vers 2 No  Hospital: 1 Inpatient 2 PR/Outpatient 3 DOA  Other 4 Nursing Home 5 Residence 6 Other:		ursing Home 5 Residence 6	Outpatient 3 DOA Other		examiner? 1 ✓ Yes 2 No	o Be	Vital I sysician: this certifi director,				
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6 = 51 1/93 Centiler.	anner as stated.	and due to the cause(s) and manner	eath occurred at the time, date and pla	an: To the best of my knowledge, On the basis of examination and	29a. Certifier 1 Certifying Physici		the Hospital hin 24 hours a the Funeral				
29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  O.C.M.E.  September 30, 2009			290. Bloating and the property 290. Block to the								
30. Name and address of person who completed cause of death (Item 23a)  Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201		MD 21201			Victor Weedn MD JD A		organo !				
State 31. Date filed (Month, Day Year) 2009 32 Registrar's Signatur			pare	32 Registrar's Signatur	31. Date filed (Month, Day Year) 20	tate trar					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b, c,e,f,perINF,G896,10/26/09,WS

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 0 gear Physician/ 6:15 PM Garland Travers Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Center Gilchrist Hospice 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Birth Country MD **Funeral** Hours Days Min. 1 2 - 30 - 55 1 🛛 M 2 🗆 F 218-64-2292 53 Director Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State Frederick frederick Director 1 ☐ YesXX No MD Baltimore Cockeysville 10f. Zip**21**701 10g. Citizen of What Country? 10e. St201nd Madeison St. Apt. Funeral 21030 USA Stoney Mill Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etAfrican 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 ANo
If Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: American 3 Widowed 4 Divorced Year or Dates marked other than "natur matic event, the Medical 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) NA Country Club Cook Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Stewart Travers Noreen Theodore R. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $\,^{
m MD}$ 19a. Informant's Name/Relationship (Type, Print) 700 Stoney Mill Court Apt. B Cockeysville Adele E. Travers-Sister 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot Druidridge Cem. 10-12-09 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Wylie Funeral Home 21. Signature of Funeral Service Ligensee 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cholansid Physician/ Corcinno montal disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Classes or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav 5 Other (specify) Pregnant at time of death ed by the a detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Within 24 hours after death.

To the Funeral Director: After this certificate has been significant to the Funeral director, page 2 should be after the tuneral director, page 2 should be aftered. 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No 24a. Was an autopsy Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred Certificate: (Month, Day, Year) 1 Natural 5 Pending Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Suicide ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) and title of certifie 29c. License number 29b. Signature OCTOSES 6 avus 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chronies un 31. Date filed 32. Registrar's Signature State

Registrar

		-	For State Registrar	State of Ma	aryland		artment of F rtificate of D		Mental Hy	giene A	009	32130			
			Decedent's Name (First, Middle, La	est)					2. Date of De	eath	Year	3. Time of Death			
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	Examin		4a. Facility Name (if not institution, giv	e street and number)		4b. City, Town, or	Location of Death								
med!			STELLA MARIS HOS	4 1 1 4t - t- 1	TIMONIU	M If Under 24 Hrs.	I a Data of Di	BALTIMORE							
	Funeral Director	1				Yrs.	Months Days	Hours Min.	8. Date of Bir (Month, Da	y, Year)	Coun	**			
			164-24-3587 Usual Residence of Decedent		78				19/2/19	31		SYLVANIA			
	yland f sho ed at	형	10a. State 10b. County		,	Town or Lo						0d. Inside City Limits			
	e Mar 7 28a- notifij	Sire	MD BALTIM  10e. Street and Number	ORE	PA	RKVIL		<u>-</u>		40.00	. (148	1 Yes 2 No			
	ith th	<u>  a  </u>					10f. Zip Code	2/1			n of What Cour S <b>A</b>	itry?			
	ems arm	Funeral Director	1896 YAKONA ROAD	12. Was Decedent E	ver in U.S.	13.	Was Decedent of H	spanic Origin? (Sp	pecify Yes or No-		. Race - Americ	an Indian,			
9	ter de , or it	by F	1 Never Married 2 Married	Armed Forces?	No		If Yes, specify Cuba  1 ☐ Yes 2 🗶 No		o Rican, etc.)		Black, White,	etc.			
9	ursat tural" al Exa	ted	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates.								ITE			
15-	72 ho n "na Nedici	Completed	15. Decedent's (Specify only highest of	rade completed)		(Give	dent's Usual Occup kind of work done o OO NOT use retired)	ation furing most of wor	king	16b. Kind	of Business In	dustry			
7	vithin iene. ir thau the N		Elementary/Seconday (0-12)	College (1-4 or 5	+)		MEMAKER			IO	WN HOME				
Maryland 21215-0036	filed within 72 hours after death with the Maryland al Hygene. other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at	B B	17. Father's Name (First, Middle, Last,		,			18. Mother's Nar	ne (First, Middle	, Maiden Sui	rname)				
ylaı	ld be Menta arkec atic e	욘	MARTIN IGNATIUS	MCGINLEY				ELIZAE	BETH M.	MCGANI	V.				
Nar	12 should be file lith and Mental F 27 is marked o r traumatic eve		19a. Informant's Name/Relationship (			1	ng Address (Street					Code)			
	and 2 Health tem 2					MARY JO WHELAN/D 20a, Method of Disposition	AUGHTER	20h Pla		OAKLEIGH	ROAD 1	OWSON,		1286 ition - City or To	own State
nor	Page 1 ment of ant: If it ury or o	П	1 🔀 Burial 2 🗆 Cremation 3 [ 4 🗆 Donation 5 🗔 Other (Spec		ce	metery, cre	matory or other place F FAITH C		10/2009	l	(VILLE,	·			
Baltimore,	2 P P P		21. Signature of Funeral Service Licer		10021		2. Name and Addres								
Ä	permit Depar Impor any in once.				10021		521 LOCH					286			
			23a. Part 1. Enter the disease, or cor shock, or heart failure. List only	nplications that caused one cause on each line	the death.	. Do not en	er the mode of dyin	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between			
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	Medical Examiner		resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):							1					
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Division of Vital Records, P.O. Box 687	ath certific attending p	Physician/M	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No		2 🔲 Fetal	death 3	☐ Ectopic pregnand ☐ Other (specify)	У		23	<ul> <li>d. Date of deliv</li> <li>Month</li> </ul>	ery Day Year			
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Re	: The law cate has ; page 2 s								1 🗌 Yes	ormed? 2 <b>X</b> No	death? 1 🔲 Yes	2 🗆 No			
ital	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 <b>X</b> No	Hospital:			_ Oth	ace of Death (Che			1	HOODTON			
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no	inding l ath. r: After ne funer	icat	1 X Natural 5 ☐ Pending 2 ☐ Accident ☐ Investigation		; Year)	injury	M 1 🗆	:? Yes 2 □ No							
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	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 144 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	(Check 2 Medical Exar	ysician: To the best of a niner: On the basis of ex rse Practioner: To the l	camination	and/or inve	stigation, in my opinio	on, death occurred	at the time, date	and place, ar	nd due to the ca	use(s) and manner stated.			
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	Ve		30. Name and address of person who	completed cause of de	eath (Item :	23a) (Type,	Print)			- /-					
			JACKIE JONES, CR	NP 2300 D			LEY RD.	TIMONIUM	, MD 21	093					
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11:35 р.т.

OCTOBER 4, 2009

MARGARET VALENCIK

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician Willis Wade Whitlock, Sr. 6:40 p <sup>M</sup> September 28, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Forest Hill Forest Hill Health & Rehab. Center If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☑ M 2 ☐ F 251-14-7841 12/12/1921 South Carolina Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location sa or 28a-f show t be notifled at 10a. State 10b. County 1 ☐ Yes 2 No Director Harford Darlington MD filed within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21034 3902 Conowingo Road "natural", or Items 23a Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 XYes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Medical (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.
s marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Chef Quarter Master Navv 12 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If item 27 is marked other
any Injury or other traumant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Leslie Mary Henry James Whitlock မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3902 Conowingo Road, Darlington, MD 21034 Ethel Whitlock/ Wife Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hanover, Maryland 4 Donation 5 ☐ Other (Specify) Anatamy Gifts Registry 10/5/2009 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Societe Livensee 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Stone Due to (or as a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unsease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) O. Box 68760, Physician/Medical the as attending IF FFMALE: use If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown þ σ. signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 s autopsy performe death? 1 ☐ Yes 2X No certificate | 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Be Hospital: Other: 4 

Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2X No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Hospital or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death. the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 32295 Ocruber 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 615 W. MacPhail Rd. Ste. 106, Belair, MD 21014 David Dunn M.D. 32. Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 7 2009 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 09 5 05 DUL /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Halethorpe 122 Fourth Avenue If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🔽 F 03/21/1934 215-30-1774 MD Director Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10c. City, Town or Location 10a. State of 2 should be filed within 72 hours after death with the Marylar thand Mantal Hyglene.
7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it is find the count in the force in the count. 1 ☐ Yes 2 ☑ No Director Halethorpe Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number U.S.A. 21227 122 Fourth Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 No If Yes, Give X Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify: Specify: White ģ 3 Widowed 4 X Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Madeline Struck Adam Kuchta ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) .. Pages 1 and 2 st tment of Health an tant: If item 27 is r jury or other trau 122 Fourth Avenue, Halethorpe, MD Deborah McVicker/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages Department of Important: If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ardent Cremation Services 10/06/2009 Hanover, Maryland 22, Name and Address of Facility Ardent Cremation Services 21. Signature of Funeral Service Licensee 21076 7522 Connelley Drive, Ste.N, Hanover, MD Marcelone 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Non Small cell carcinoma **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 X No P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Caucer Completed 24b. Were autopsy findings available prior to completion of cause of death? obstructive pulmonary 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2/10No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 MNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of ath 28c. Injury at Work? Certification: 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARKKIM, MD GIEN BURNIE MD 21061 6A

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 9 per fh 8896 10-9-09 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year Physician WriGH  $P^{M}$ September 24, 2009 1:45 eLUIN /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson 8. Date of Birth Month, Day, Year) Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) **Funeral** Min Months Days Hours 217-82-891 Yrs. 3 Maryland an. 196 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: If item 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Expressor must be notified at 1XYes 2 □ No Funeral Director altimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number Kenwood 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Union memorial College (1-4or 5+) Elementary/Secondary (0-12) HUSPITAL adiologiST Lith 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be h and Mental F should be 2 19a Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wright md. 212/3 - Sider Pages 1 and 2 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20g. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature Juneral Service Licen 22 Name and Address of Facility 23a. Patr. 5 the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line. mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate (muse (Final **Physician** ardiomyopathy disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last death certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical as the t IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. cate has been signed page 2 should be det Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 No. 1 ☐ Yes After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: npatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending Natural 5 Pending investigation To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fune 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0058082 30. Name and address of pen n who completed cause of death (Item 23a) (Type, Print) Suite SSO N. Pavillion, Towson MD 21204 N. Charles Gosnell 6535 Mark 31. Date filed (Mo State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 12:00 PM 2009 October Nelson Waataja Margaret /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Prince George's 2700 Felter Lane Bowie If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Jan. 24, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours Min. 1 □ M 2 🛛 F 1922 577-22-6775 Maryland 87 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 28a-f show r than "natural", or items 23a or 28a-f show the Medical Experienment be notified at 1 X Yes 2 No Director Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20715 2700 Felter Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: Specify: White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Reseacher Library of Congress 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be be 1 and 2 should be Health and Mental John L. Smith Lula Poland other traumatic ပ permit. Pages 1 and 2 should Department of Health and Mt Important: If item 27 is mark any injury or other traumatit Once. 19a. Informant's Name/Relationship (Type. Print (Husband) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2700 Felter Lane, Bowie, MD 20715 Robert Wallace Waataja 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 Removal from State Metropolitan Crematory 10/4/09 Alexandria, VA 4 Dopation 5 ☐ Other (Specify) 22. Name and Address of Facility Jefferson Funeral Chapel 21. Sign, ture of Funeral Service Licensee 5755 Castlewellan Dr., Alexandria, VA 22315 ennis meen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Hypertension disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Arteriosclerosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-trar Due to (or as a consequence of) P.O. Box 68760 physician use as attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) the 9 Unknown signed by t 1 be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed? 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \subseteq Nursing Home 5 \subsetex Residence 6 \subseteq Other (Specify) 1∭Yes 2☐No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this After the funeral 28b. Time of 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 X Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and place and place and place. within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number October 3, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6001 Landover Rd., Cheverly, Maryland Gladys Heatley, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Parket Registrar

DHMH 17 Rev 1/2001

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Maryla	•	iπment of He tificate of De			Jiene Neg. No. 2 () () (	9 32136	
	Physicia		1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Yea  OCCUPATION  A Discourse Lighting							3. Time of Death	
	Medic	dicalHIAWALHA FIETTE WALKINS						October	4, 2009 4c. County of De	8:00 AM M	
	Examin	er	Gilchrist Hospice  Towson						Baltim		
	Funeral		5. Social Security Number 6. Sex	7. Age (In yi	rs. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth	9. B	irthplace (State or Foreign	
	Director		212-34-6036 1A  Usual Residence of Decedent	]M 2 □ F	73 Yrs.	World S Bays	TIOUIS IVIIII	Apr 25,	1936 Ma	ryland	
	and show	l 1	10a. State 10b. County	10c.	City, Town or Loc	eation				10d. Inside City Limits	
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	th the 3a or t be n	al D	10e. Street and Number 5210 Thunderhill	Dood		10f. Zip Code	.045		10g. Citizen of What 0 USA	Country?	
	ath wi	Funeral Director		12. Was Decedent Ever in	U.S. 13. V			cifv Yes or No-	14. Race - Am	perican Indian	
ထွ	or ite		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 X Yes 2 ☐ No		Vas Decedent of Hisp Yes, specify Cuban,		Rican, etc.)	Black, Wh	ite, etc.	
8	urs af tural" al Exa	Completed by	3 Widowed 4 Divorced		1-62	☐ Yes 2 🌠 No			Specify: b1		
15-	72 ho n "na Nedic	nple	15. Decedent's Edi (Specify only highest grad	e completed)	(Give F	lent's Usual Occupation  ind of work done duri  NOT use retired)		ng	16b. Kind of Busines	s Industry	
212	within giene. er tha		Elementary/Seconday (0-12)	College (1-4 or 5+) 5+	1110. 24	chemis	t		resear	rch	
pu	filed all Hyg		17. Father's Name (First, Middle, Last)		-	1	8. Mother's Name	•			
yla	uld be I Ment narke	욘	Hiawatha Watkins		<u> </u>		Addie C				
Ma	12 shoralth and 27 is n		19a. Informant's Name/Relationship (Type India C. Watkins)			g Address (Street and Thunderh			City or Town, State, 2 ia, MD 21	Zip Code) 045	
Baltimore, Maryland 21215-0036	permit, Page 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cromation 3 ☐ 1 4 ☒ Donation 5 ☐ Other (Specify)	Removal from State	b. Place of Dispo- cemetery, crem	sition (Name of natory or other place)	С	Date	20c. Location - City of	or Town, State	
Balt	permit, Departr Import any inji		21. Si nature of Euneral Same Rice Se	ade, Direct		Name and Address ate Anatoi Itimore. N			Baltimore	Street	
П		23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between	
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Undership Cause (Disease or linjury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  C. Due to (or as a consequence of):								
	aath certificate be executed attending physician and for use as the burial-transit	edical Examiner									
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68760	ficate g phys										
39 ×	h certif tending r use a	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pre 1  Live Birth 2  1		Ectopic pregnancy			23d. Date of d		
. Box	ne deat / the at ched fo	Physician/N	1 Yes 2 No	4 ☐ Pregnant at time g ☐ Unknown	of death 5	Other (specify)			Month	Day Year	
P.0.	requires that the de been signed by the should be detached	by PI	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause giver	n in Part I.			to the cause of death?	
rds,	equires een sig	ted						1 🗆 Y		Probably 4 Unknown	
Division of Vital Records,	2 48	Completed						24a. Was a autops perform	sy prior to med2 death?	autopsy findings available completion of cause of essential No	
ital	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:		_ Other	e of Death (Check		N.	llo-O'	
of V	g Phys er this eral dii	e: 10	27. Manner of Death	1 Inpatient 2 28a. Date of injury	28b. Time of	t 3 □ DOA 28c. Injury a			ence 6 A Other (Spe ow injury occurred	ecify) TOX (ICO	
ono	anding sath. ir: Afte	ficat	Natural 5 Pending 2 Accident Investigation	(Month, Day, Year	) injury	M work?	es 2 🗆 No				
Jivisi	Hospital or Attending 24 hours after death. Funeral Director: After sted filled in by the funer	Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - A building, etc. (Spe		et, factory, office 28f. Location (Street and Number or Rural Roc City or Town, State)		iural Route Number,			
	To the Hospital or Attending Physician: The Is within 24 hours after death.  To the Funeral Director: After this certificate his completed filled in by the funeral director, page	Medical	(Check 2 Medical Examin	cian: To the best of my kner: On the basis of examina Practioner: To the best of	ation and/or invest	igation, in my opinion,	death occurred at	the time, date an	nd place, and due to the	e cause(s) and manner stated.	
	To the within 2		29b. Signature and title of certifier		^	29c. License n			29d. Date signed (Mor		
	)		Haberca Sett	ull Chit		KI45	25/26	(	Ctober 4	12009	
			30. Name and address of person who co	mpleted cause of death (I	item 23a) (fype, P	rint)	n River	1 Tous	m MA	21204	
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sig	gnature		<u> </u>			V	
	Registra	ar	UCI 0 7 200	3 Chreva	B. 100	West					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #1 State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year q Physician 45PM SA 200 C. Wilson George /Medical Facility Name (If not institution, give street and number, 4b. City, 4c. County of Death Examiner Belair Healthand Rehabilitation Cente BEI Air Hartor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Days Year Hours Months 1 M 2 □ F 191-16-9264 86 Director June 12, 1923 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Mouldon Exhibited. 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐Yes 2√ No Director MDHarford Aberdeen 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1636 Perryman Road 21001 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ∐Yes 2XINo 2 Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) office manager PA railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Kohler Joseph H. Wilson ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3819 Janbrook Road Randallstown, MD 21133 19a. Informant's Name/Relationship (Type. Print) Gary Caplan/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Ronal S. Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate (Final disease or condition resulting in death) letastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner Due to for as a nonsequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-trai Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 □No 24a. Was an 1 □Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗖 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

P.O. Box 68760, Records, of Vital Division

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed and use for director, page 2 should hours after deatluneral Director: 24 hours a

> 31. Date filed (Month, Day, Year) OCT 0 7 2009 State Registrar

SHILPI

29a, Certifier (Check only one)

29b. Signature and title of certifier

John

206 HAYS 2. Registrar's Signature

and manner stated.

MD

KHI DELA

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

21

1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D56545

#102 BEL A12, MD

29d. Date signed (Month, Day, Year)

9/3409

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician 6:10PM /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Baltimore Kandallstown Seasons Haspice - Northwes If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral 1 M 2 □ F Days 220-76-9562 Director Usual Residence of Decedent 10d. Inside Offv Limits 10b. County 10c. City, Town or Location or items 23a or 28a-f show 1 PYes 2 □ No Maryland Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 2 3 Widowed 4 Divorced Year or Dates and Mental Hygiene. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Paula ٩ Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any injury or other trau Baile nother BaHIMORE 20b. Place of Disposition (Name of cemetery, crematory or other t 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State remater 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) End-Stage **Physician** /Medical Due to (or as a con equence of) Examiner Sequentially list conditions, if any, leading to immediate cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 □No 1 🗌 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 6 Wother (specify) Other: 4 \(\sum \) Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Residence 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 715 Rajapahse M.D DOD 57465

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N.S. Rajapakse, MiD.

31. Date filed (Month, Day, Year)

25 Main St., Suite 200, Reisterstown, MD. 21136

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Barcroft WALLACE 4, 2, 109 4c. County of Death Inn /Medical 4a. Facility Name (If not institution, give street and number)

3611 44th Street, 4b. City, Town, or Location of Death Examiner NIA Brookly If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 36 Months Min 218-84-2654 Usual Residence of Decedent 1 □ M 2 🖫 March Director 10d. Inside City Limits State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at 1XYes 2 ☐ No Director ma 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō 212 items 23a Funeral filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11 Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 □Yes 2 No Specify: White 21215-0036 ,o Specify. þ 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than College (1-4or 5+) Elementary/Secondary (0-12) Stati manager Baltimore, Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 should be fi and Mental I arcineFT Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any Injury or other train metrius 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 109 CREMATORY METRO 22. Name and Address of Facility 21. Signature of Funeral Service Licensee eto, md. 21229 ere 2 m. Wa 23a. Part 1. Enter the disc. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fail or . List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MORBID **Physician** MANY YEARS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter cruerlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine death certificate be executed burial-transit and Due to (or as a consequence of) physician Physician/Medical the attending p for use as t IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 mon 1 Yes 2 No 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) as been signed by the 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 DIABETTES 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed HYPERTENISION 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy page 2 0 No certificate HYPOTHYROIX 1 □ Yes 1 ☐ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/100 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

Box 68760. Ö Records, of Vital To the Hospital or Attending Division

within 24 hours after death.

To the Funeral Director: completely filled in by the f

State Registrar

ical

29a. Certifier

(Check only one)

29b. Signature and title of cortifier e

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARLOS D .21GEL

M.D. SUTTE 106 32. Registrar's Signature

140C SOUTH CRAIN HWY, GLEN BURNIE MS. 21061

1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number 2 5 8 0 7

29d. Date signed (Month, Day, Year)

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 0745 a<sup>M</sup> WHITE KERMIT October 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center HARFORD CO Belair If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 X M 2 □ F 87 APR. 12 1922 231-18-6861 VIRGINIA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo MARYLAND HARFORD CO **EDGEWOOD** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1929 STEVEN DRIVE 21040 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 45/40 Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: BLACK 45/46 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRANSPORTATION AUTOMOTIVE SURGEON 11th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CECILIA BOOKER STEPHEN WHITE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pastor Edward White Sr./Brother 619 Wampler Rd., Middle River, Maryland 21220 Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XX urial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) OWINGS MILLS, MARYLAND GARRISON FOREST 10-13-09 21. Signature of Funeral Service Did 22. Name and Address of Facility WILLIAM C BROWN COMM FUNERAL HOME-HARFORD, P.A 321 S. PHILADELPHIA BLVD., ABERDEEN, MD 21001 Fart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Wast only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Dav. Year)

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Directo

by Funeral

Completed

Be

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ed other than "natural", or items 23a or 28a-f shov event, the Medical Examinar must be notified at

2 should be filed within 72 h and Mental Hygiene. Is marked other than "nat

1 and 2 should be fi Health and Mental F

or other traumatic

permit. Pages 1 and 2 Department of Health a important: if item 27 is any injury or other trai once.

Maryland

Baltimóre,

attending physician

law requires that the death certificate be

or Attending Physician: The

Records,

Division of Vital

Physician/Medical g Completed Be

1 ∐ Yes 2 📉 No

5 Pending

investigation

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500

2. Registrar's Signature

6 Could not be determined

27. Manner of Death

1 Natural 2 ☐ Accident

3 Suicide

29a. Certifier

4 🗌 Homicide

(Check only one)

29b. Signature and title of certifier

31. Date field (Month, Day, Year)

Certification: To

24 hours after death Funeral Director:

To the

Medical

1 Inpatient 2 ER/Outpatient 3 DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Injury

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28a. Date of Injury (Month, Day, Year)

		Please Type or Print in Black Indelible Ink. Ensur				
		State of Maryland / Department of Health a	nd Mental H		75 200 200	S O 1 1 1
		Registrar Certificate of Death	2. Date of I	Reg. No		3. Time of Death
Physic	cian	1. Decedent's Name (First, Middle, Last)  Mary A. Anderson	Month Sept	14	, 2009	12:00P M
/Med Exam		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of			. County of Deat	
Exam	iriei	Southern Maryland Hospital Clinton, Mary			ince Geo	
Funera	ı	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 2 Months Days Hours	Min. 8. Date of E Month, April	Birth Day, Year	9. Birt	hplace (State or Foreign untry) ginia
Directo	r	Usual Residence of Decedent	Aprii	23,	1917 VII	gilla
yland now		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
Maria-fish	ctor	Maryland Prince Georges Temple Hills,				1 ∏Yes 2 □ No
paritimore, interpretable and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 ia marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Medical Evanination positions and injury or other traumatic event, Ite Medical Evanination positions.	Director	10e. Street and Number 3420 Rickey Avenue, Apt #346  10f. Zip Code 20748		_	itizen of What Co	
sath w	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Property of the Control of Hispanic Original Property of Hispanic Ori	nin? (Specify Yes or	L	14. Race - Ame	
ter de	Ē	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 2 □ Married  1 □ Yes 3 □ No If Yes, Give  1 □ Yes 3 □ No Specify:  1 □ Yes 3 □ No Specify:	Puerto Rican, etc.)		Black, White	e, etc.
urs al	٥	If Yes, Give 1 1 ☐ Yes X No Specify: Year or Dates:			Specify: B1	ack
72 ho	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most	of working	16b. I	Kind of Business/	Industry
within see.	100	Elementary/Secondary (0-12) College (1-4or 5+)  Audit Control Super	visor	DC	Governme	ent
filed Hygical	ပိ		r's Name (First, Midd	lle, Maide	n Surname)	
ld be Mental rked o	To B	James Strother Ficklin Vall	ie Davenpo	ort		
2 shot and had a ma	ľ	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number				
and and and m 27		Ardala Simms (Daughter) 905 Marcy Avenue, O	xon Hill,		20745 Ap	ot #T-4
Pages 1 nent of H int: If itel		20a. Method of Disposition  1☑ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition (Name of cameter, crematory or other place)  Ft. Lincoln Cemetery	10-01-09	1	ntwood,	
it. Pa trtmer rtant: njury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licenses Power Power Of Funeral Service Licenses Power		_		
permit. Departr Importa	olice	5538 Marlboro P:			le. MD	20745
		23a. Part1. Enter it disease, or complications the caused the death. Do not enter the mode of dying, such as shock, or here failure. List only one cause on each line.				Approximate Interval Detween
Physiciar		shock, or he in failure. List only one cause on lach line.  Immediate Cause (Final disease or condition				Oriset and Death
/Medica		resulting in death)  Due to (or as a consequence of):	334 (33)			N 1
Examine		Sequentially list conditions.  b. Hymnumie Condition	desea	se		25
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Toully			1 month
e execuan and and rial-tra	Exa	that initiated events resulting in death) Last Due to (or as a consequence of):	700000			
E iii E						
artificate	Physician/Medica	IF FEMALE:				
ath ce	jan/	23b. Was decedent pregnant in the past 12 months?				livery Day Year
he de / the a	Vsic	1 ☐ Yes 2 No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Other (specify)				
that the hed by detail			23e. D	id tobacco	use contribute t	o the cause of death?
w requires to be a signal should be	be be		1	Yes	2 <b>▼</b> No 3□ P	robably 4 🗌 Unknown
aw reas bec	a d		24a. W	as an	24b. Were a	utopsy findings available completion of cause of
The I	Completed		l Die	orformed?	death?	·_
VILAI Iclan: T sertifical ector, pa	B B	25. Was case referred to medical examiner?	of Death (Check on			
Physic rathis or ral dire	ļ.		rsing Home 5 ☐ R		6 ☐ Other (Spa	ecify)
ng ng	į	27. Manner of Death 1 Matural 5 Pending 2 Accident investigation 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 4 Work? 1 Pending 4 Injury 4 Month, Day, Year) 4 Injury 5 Injury at Work? 4 Injury 6 Injury 7 Injury at Work?			,	
Attending or death. ector: Afte by the fune	iji	3 ☐ Sulcide 6 ☐ Could not be 4 ☐ Hornicide determined building, etc. (Specify)		n (Street : Town, Sta		lural Route Number,
tal or safte al Dire	Certification:	4   Hornicide building, etc. (Specify)	Only of			
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: Afte completely filled in by the fune			nd place, and due to ath occurred at the ti	the cause ne, date a	e(s) and manner a and place, and du	as stated. le to the cause(s)
thin 2 the l	Medical	one) and manner stated.  29b, Signature and title of certifier 29c, License number		29d. E	Date signed (Mor	th, Day, Year)
F 5 2 5 8		D-245	35	6	9 15	09
14		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		1 - 1	11 - 1	1 10070 -
<u> </u>		La Fill John College C	to 1010	lint	111,00	1 40/35
	tate	SEP 2 4 2009 Server B. Garles			,	
Regis	strar	DEP & 4 LOUS Chause 1/0. Harry				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink 5794 All Copies Are Legible.

Amend Item 23a per phys. 6896 107794 All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Sept Physician/ MILDRED ALBRIGHT 12:00 PM VIOLA Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Gilchrist Center Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country 1 □ M 2 💢 F Months Hours Min. 4 /9 P P 8 8 8 Director 3-26-6969 1.00 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 X No Harford MD. Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 3133 Jarrettsville Pike United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2X No Specify White 3 XWidowed 4 ☐ Divorced Specify: Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Housewife Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Harry Cowman Daisy V. Henry 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21084 3868 Jarrettsville Pike Jarrettsville, MD Robin Albright (Granddau. 20a. Method of Disposition
1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Garroll 9/24/2009 Hampstead, Maryland 4 Donation 5 Other (Specify) Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home, Part 1. Enter the disease, or complications that glused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final omplete heat block disease or condition resulting in death) Due to (or as a consequence of): vears Examiner within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the bunal-transit

Ph sician/ Medical Examiner

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Completed by Physician/Medical Certificate: To Be

Cognentially list conditions	Coronary Artery Disease		years							
If any, leading to immediate cause. Enter Underlying Cause (Disease or linjury	Due to (or as a nonsequence of):									
resulting in death) Last	Due to (or as a consequence of):  d.									
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	1 Live Birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) Month								
Part II. Other significant conditions	contributing to death but not resulting in the underlying cause given in Part I.		use contribute to the cause of death?							
use. Enter Underlying use (Disease or limjury at initiated events sulting in death) Last  EMALE:  b. Was decedent pregnant in the past 12 months? 1	24a. Was an autopsy performed? 1 \( \text{Yes} \) 2 \( \text{N} \text{No} \)									
25. Was case referred to medical	26. Place of Death (Che	eck only one)								
	Hospital: 1	Home 5 Residence	6 Nother (Specify) Gilchnist							
2 Accident Investigati	28a. Date of injury (Month, Day, Year)  28b. Time of injury 28c. Injury at work? 1 □ Yes 2 □ No	28d. Describe how inju								
	29e Dlace of Injury - At home tarm street factory office	28f. Location (Street a City or Town, State	nd Number or Rural Route Number, e)							

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar DHMH 17 Rev 7/2009

To the Hospital

Medical

29a Certifier

29b. Signature and title of certifi

31. Date filed (Month, Day, Year)

CRNP

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) September 23, 2009

6701 N. Chales St

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** September 22, 2009 605 PM M Allen Abraham Buchalter /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery The Landow House Assisted Living Rockville 8. Date of Birth 1 2 1 5 ear, 9. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** Days Months Min. Hours 578-32-1802 1⊠ M 2□ F 93 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examination to redified at 1X Yes 2 □ No death with the Mar Director Montgomery Rockville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 1799 East Jefferson Street #209 20852 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕅 No Specify: ģ Specify: White 3 √ Widowed 4 □ Divorced Completed Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. U.S. Army Corps Elementary/Secondary (0-12) College (1-4or 5+) Chief of Publication and Graphics 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any liny or other traumatic event angle. Be Nettie Kite Louis Buchalter ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Kessler - Stepson 11940 Marmary Road Gaithersburg MD 20878 20b. Place of Disposition (Name of cemetery, crematory or other place King David Memorial Gardens Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 09/24/09 Falls Church, VA 22. Name and Address of Facility
Edward Sagel Funeral Direction Inc
1091 Rockville Pike Rockville MD 21. Signature of Funeral Service Licenses M01163 23 f. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pleural Effusion /Medical Due to (or as a consequence of): Examiner Lung Cancer Sequentially list conditions, if any, leading to immediate cause. Enter any injury cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physiclan: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛛 Unknown Completed 24a. Was an autopsy 24b. Were autopsy findings available prior to completion of cause of death? performed 2 🕅 No 1 ☐Yes 2 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other:
4 Nursing Home 5 Residence 6 Tother (Specify) Living Certification: To 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 🖫 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after deatle Funeral Director: Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1☑ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only onel within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 31. Date filed (Month, Day, Year)

SEP 24

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

parked

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Gary Fisher MD 5530 Wisconsin Avenue #700 Chevy Chase MD 20815

32 Registrar's Signature

D13818

September 23, 2009

		-	For State of Maryland / Dep 1 - State Registrar Co	ertificate of Death	Reg. Ne	130000	32144				
	Physicia	an	1. Decedent's Name (First, Middle, Last) Gloria Johnson Branham		2. Date of Death Month Da September	ay Year	3. Time of Death  2:52 A M				
1	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	·	c. County of Death					
. 1	Examin	er	3325 Leonard Town Road	Waldorf		Charles					
	Funeral Director		5. Social Security Number $219-38-5274$ 6. Sex $1 \square$ M $2 \square$ F $68$ Yrs.	/ If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Year 04/12/194	9. Birth Cou Mary	place (State or Foreign ntry) Land				
	and w		Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or I	ocation			10d. Inside City Limits				
	Maryla f sho	ţō	MD Charles Waldorf				1 ☑ Yes 2 ☐ No				
$\supset$	r 28a	irec	10e. Street and Number	10f. Zip Code	10g. C	itizen of What Cou	intry?				
V	th wit	a D	3325 Leonard Town Road	20601	USA						
Baltimore, Maryland 21215-0036	be filed within 72 hours after death with the Maryland that Hyglene. Indocther than "natural", or items 23a or 28a-f show event, its l'edicel Everting must bur diffic de	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☑ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl 1 ☐ Yes 2 ☑ No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify:Mona					
2-0	72 ho	Completed	(Specify only highest grade completed) (Gir	edent's Usual Occupation re kind of work done during most of work		Kind of Business/Ir	ndustry				
121	within iene. • than "	ldmo	Elementary/Secondary (0-12) College (1-4or 5+)	nager	Eco	onomy Sto	orage				
d 2	filed Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, Maide						
ılan	2 should be f h and Mental I 7 is marked of raumatic eve	To B	James Johnson	Letitia	Christian 1	Branham					
lar,	2 sholl and I small ls mall auma		22/	ling Address (Street and Number or R							
€,	and lealt m 2		deorge whitework former habbana	Bailey Sawmill Roa		Location - City or T					
Jor	tges 1 nt of H : If ite		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State  20b. Place of Discernatory State  St: Paul	position (Name of equatory or other place)  1 Cemetery 09/2		-					
Ħ	permit. Pages 1 Department of H Important: If Ite any injury or ot once.		4 □ Demation 5 □ Other (Specify)	1 Cemetery : U9/2 22. Name and Address of FacilityDat	24/2009   Aml zansky-Golo	dberg Men	norial				
B	Dep any		M01255	22. Name and Address of Facility Dar Chapels, Inc. III Roc	kville, MD	e 20852					
			23a. Dert 1. Enter the disease, or complications that caused the death. Do not a shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death				
-	Physician		Immediate Cause (Final disease or condition resulting in death)	conce	·						
7	/Medical Examiner		Due to (or as a consequence of):								
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Unaching Cause (Disease or injury								
Ь	ifficate be executed g physician and as the burial-transit	Examiner	that initiated events c.								
68760,	be exe	EX	resulting in death) Last Due to (or as a consequence of):								
387	ficate physi s the t	edical	d								
O. Box	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me		B		23d. Date of deli Month	ivery Day Year				
σ.	that I		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco	o use contribute to	the cause of death?				
rds	w requires to be should be	ed by			1 ☐ Yes	2 □ No 3 □ Pr	obably 4 Unknown				
of Vital Records		Complete	complete	Complete	Complet	Completed			24a. Was an autopsy performed? 1 □ Yes 2 □	prior to death?	topsy findings available completion of cause of 2 □ No
Vita	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medical examiner?	Other:	ath (Check only one)						
	Phys er this eral di	5 :r	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	Home 5 Residence 28d. Describe how in		city)				
ion	nding lath. r: After e funer	atior	1 Natural 5 ☐ Pending (Month, Day, Year) Injur 2 ☐ Accident investigation	Work? M 1 □ Yes 2 □ No							
Division	the Hospital or Attending hin 24 hours after death. the Funeral Director: After mpletely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Ru ate)	ural Route Number,				
	To the Hospital within 24 hours a To the Funeral completely filled	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and place investigation, in my opinion, death occurred.	curred at the time, date a	and place, and due	to the cause(s)				
_	vithii To th	Ž	29b. Signature and title of certifier	29c, License number	29d. I	Date signed (Monta	h, Day, Year)				
	1		144000	10792)	4 9	-18-	09				
_			30. Name and address of person who completed cause of death (Item 23a) (Type 17 o 3	e, Print) Krishan, M. Ma	thur, M.D.	-064	6				
7	Sta Regist		31. Date filed (Month, Day, Year)  SEP 2 4 2009  SEP 2 4 2009	K.S.							

Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 22, Year 2009 **Physician** 122 P M Frances Block /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Montgomery Silver Spring 702 Chichester Lane 8. Date of Birth (Month, Day, Year) 03/17/1915 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 🗓 F Months New York 212-76-2093 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show 1 Yes 2 □ No MD Bethesda Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7401 Westlake Terrace #1214 20817 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 No <u>Ş</u> 3 X Widowed 4 □ Divorced Year or Dates "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry event, the Medical 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important; If item 27 is marked other than "any Injury or other traumatic event. It was Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Bernstock Arthur Baer 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 702 Chichester Lane Silver Spring MD 20904 Harriet Chachkin - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 X Removal from State King David Memorial 09/24/09 Falls Church, VA 4 Donation 5 Other (Specify) 22. Name and Address of Facility Edward Sagel Funeral 1091 Rockville 21. Signature of Funeral Service Licenses Pike Rockville MD 20852 <del>M01</del>163 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Colovesical Fistulz Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Diverticulosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of) Exami and burial-trar Due to (or as a consequence of) attending physician Physician/Medical the as use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year for in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) the 9 Unknown 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown icate has been s page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 X No certificate 1 ☐ Yes 2 X No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Xother (Specify) Home examiner' Hospital: 1 ☐ Yes 2 🕅 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

law requires that the death certificate be executed Box 68760, P.0. Records, Division of Vital Physician: spital or Attending Pilours after death, neral Director. After filled in by the funera To the Hospital or Within 24 hours af To the Funeral Di

within 72 hours after death

Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 36816

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Marsha J. Seidelman MD 10301 Georgia Avenue Suite 304 Silver Spring MD 20902

State Registrar

Medical

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year September 21 2009 $A^{\ \mathsf{M}}$ 0005 Wilma A. Brown 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Allegany WMHS-Frostburg Nursing & Rehab Center Frostburg | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | April II, 1920 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 □ M 2**X** F Maryland 89 170-38-0229 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 X No Grantsville Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21536 2015 Pigs Ear Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 21 No Specify: Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nursing Home Nursing Assistant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Clara Harman George Speicher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1409 Pigs Ear Rd., Grantsville, MD Terry R. Brown/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State St. John's Lutheran Cem. Sept. 2\beta, 2009 Accident, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Newman Funeral Homes, P.A. 21. Signature of Furneral Service Dicenses P.O. Box 275, Grantsville, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hart Congestive 24e425 disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) 4☐Pregnant at time of death 1 ☐ Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

**Physician** /Medical Examiner

and

**Physician** 

/Medical

**Examiner** 

**Funeral** 

**Director** 

r 28a-f show notified at

"natural", or items 23a or

d other than "natur event, the Medical E

Ith and Mental Hygi 27 is marked other r traumatic event, ti

permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any Injury or other trau

**Funeral Director** 

Completed by

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

physician als the burial-1 within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

Examine Physician/Medical 9 Completed Be Certification: To

							1   Yes 2	JNO 3 Probably 4 Onknown
							24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 No
25. Was case refer	red to medical				26.	Place of Dea	th Check onl one	
examiner? 1 ☐ Yes 2	No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatient	3 DO	Other: 4	Nursing H	iome 5 Residence 6	Other (Specify)
27. Manner of Deat  1 Natural 2 Accident	h 5	28a. Date of Injury (Month, Day Year	28b. Time of Injury	M 2	8c. Injury at Work? 1 ☐ Yes	2 □ No	28d. Describe how injury	occurred
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined		t home, farm, stree	t, factory	, office		28f. Location (Street and City or Town, State)	l Number or Rural Route Number,
29a. Certifier (Check only	1 Certifying Ph	nysician: To the best of my miner; On the basis of exam	knowledge, death oination and/or inve	occurred stigation	at the time, d	ate and place n, death occu	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)

State

Medical

WONSOCK

worreckshi

925 Bishop MD

00055325

Walsh Rd Cumberland

29c. License number

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

Registrar

			For State Registrar	State of Mary		ertificate of L			eg. No.	nne	32167
	Dhysisis		1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day 21	2 <sup>ve</sup> a 9	3. Time of Death 12:35а м
4	Physicia /Medic		Wayne Burto			1 u o: T	Lucation of Dooth		1	2009 ty of Death	12.55a W
	Examin	er	4a. Facility Name (If not institution, give s Carroll Hospice D			4b. City, Town, or	inster			rro11	
*	Francis		5. Social Security Number 6. Sex		yrs. last birthda	y) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth			lace (State or Foreign try)
	Funeral Director			M 2□F 71	Yrs.	Months Days	Hours Min.	Dec 13	1937	00077	MD
	pu ,		Usual Residence of Decedent  10a, State 10b, County	10	c. City, Town or	Location				1	Od. Inside City Limits
	shov	'n	10a. State 10b. County 10b. Carroll		Sykesvi						1 □ Yes 2 No
	the N	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen o	f What Coun	try?
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examinations to rotified at		6403 Bonnie Brae	Road		21784			USA		
	death	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	r in U.S. 13	3. Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp n. Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. R	ace - Americ	an Indian, etc.
92	after or ite	y Fu	1 Never Married 2 Married	1 <b>X</b> 1Yes 2 ☐ No If Yes, Give	1957- 1963	1 □ Yes 2√□ No	Specify:			white	
Ö	hours tural";	ed by	3 X Widowed 4 □ Divorced	Year or Dates:		cedent's Usual Occup	ation		16b. Kind of		
5	in 72 n "nal	Completed	15. Decedent's Educ (Specify only highest grade	e completed)	(Gi	ve kind of work done on DO NOT use retired	turing most of work				-
212	d with giene ir thau	mo	Elementary/Secondary (0-12)	College (1-4or 5+)	m	eat cutter			groo		
p	al Hy al Hy I othe	Be (	17. Father's Name (First, Middle, Last) Allen Burton				18. Mother's Nam Geneva		Maiden Surn	ame)	
<u>yla</u>	Ment Ment arkec	To.							C" T	01.11. 75	0-4-1
۸ar	12 sh h and 7 is m traum	1	19a. Informant's Name/Relationship (Ty Kathleen Burton (			ailing Address <i>(Street i</i> B Bonnie Br					
Baltimore, Maryland 21215-0036	1 and Healt em 2		20a. Method of Disposition			sposition (Name of rematory or other place			20c. Locatio		
JOL.	ages ent of nt: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Cother (Specify)	removal from State			. 0 01	-09	Sykest	ville,	MD
alti.	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marital Examination in all be notified at once.		21. Signature of Funeral Service Licens	ee,		22. Name and Addre	ss of Facility Ha	ight Fun	eral I	Home &	Chapel
m	P E E G		Parge Haight			P.O. Box 1				34	
П			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	cations that caused the ne cause on each line.	e death. Do not	enter the mode of dyir	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition resulting in death)	ilisant.	- M	Cuil in	ı				
Į.	/Medical Examiner		resulting in death)	Due to (or as a co	onsequence of):		moma				
		e	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury	Due to (or es a ru	unitiequentie of):	ucc	m Da				
	od d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events								
ó	e exec ian an ırial-tr		that initiated events resulting in death) Last	Due to (or as a co	onsequence of):						
68760,	ficate be executed physician and sthe burial-transit	edical		d							
_	certific ding p		IF FEMALE:	23c. If yes, outcome of p	pregnancy				234	Date of deliv	erv
Вох	eath certif attending for use as	cian	in the past 12 months?	1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tin	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	Ey			Month	Day Year
o.	the d	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown							
۳.	The law requires that the death certi ate has been signed by the attending page 2 should be detached for use a	by P	Part II. Other significant conditions co				en in Part I.		,		he cause of death?
ğ	w require s been sig should b	ed b	wter tetre	Carun	sma	prince	_	1 □ Y	es 2 N	o 3∏ Pro	bably 4 Unknown
ecc	e law re has be je 2 sho	plet				unlar	hun.	24a. Was a	sv	prior to co	opsy findings available ompletion of cause of
= E	ding Phystcian; The P.n. After this certificate ha funeral director, page	Completed						perfor 1 ☐ Yes	med? 2 ☑No	death? 1 ☐ Yes	2 🗆 No
Vita	slcian: The certificate I rector, page	a	25. Was case referred to medical examiner?	Hospital:		Oth	nr:	th (Check only or			- Agriculture
Division of Vital Records,	Attending Physician: #r death. ector: After this certific by the funeral director,	5	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	2 ER/Outpa	e of 28c. Inju	ry at	ome 5 ☐ Resid			TOSPICE
on	nding th. Afte tune	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Y	<i>(ear)</i> Injui	ry Wor	·k̃? ]Yes 2 □ No				
Visi	Attendi	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc. (	- At home, farm,	street, factory, office		28f. Location (S City or Tow	Street and Nu	ımber or Rui	al Route Number,
Ö	tal or rs afte al Dir ed in	Certification:									
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the fu	Medical	29a. Certifier 1 Certifying Phy (Check only one)	vsician: To the best of r iner: On the basis of ex and manner stated	xamination and/o	eath occurred at the t or investigation, in my	ime, date and place opinion, death occu	e, and due to the irred at the time,	cause(s) and date and pla	d manner as ce, and due	stated. to the cause(s)
	o the ithin of the omple	Med	29b. Signature and title of certifier	0		29c. Licens	se number		29d. Date si	gned (Month	, Day, Year)
	200			uken	50	1	131515	-	9	1211	09
	W.		30. Name and address of person who c	ompleted cause of deal	th (Item 23a) (Ty	pe, Print)					09 08
	5		Andrew Becken	32. Registrar's	15	waller	Are	(sat	tinn	0 m	D CIONS
	Sta Regist	ate	31. Date filed (Month, Day, Year)		d A	backer					

		<ul><li>State Registrar</li></ul>		Ce	artment of tertificate of			Reg. No	C 11 U 5	321	45
		1. Decedent's Name (First, Middle, Last)					2. Date Mon	of Death ith Da	y Year	3. Time of I	Death
hysicia /Medica		James Bouknight			· · · · · · · · · · · · · · · · · · ·			9/19/09		2321	M
xamine	4	la. Fecility Name (If not institution, give s		1 0 .		or Location of De		40	County of Deal		
		Prince George Count  5. Social Security Number 6. Sex		I Center In yrs. last birthday		Cheverly If Under 24 H	rs. 8 Date	of Birth	9 Birl	George thplace (State or ountry)	
neral ector		212-12-4962	M 2 F	92 Yrs.	Months Days		n. 06/	14/191	7 Sou	ountry) ith Caro	olina
	-	Usual Residence of Decedent  10a, State 10b, County	1	Oc. City, Town or L	ocation					10d. Inside Cit	ty Limits
	ctor	Maryland Prince G	eorge			Landove	r			1 <b>∏</b> Yes	2 No
	Director	10e. Street and Number  5 Norair Aven			10f. Zip Code	785		10g. Ci	itizen of What Co United		
	era		12. Was Decedent Ev	er in U.S. 13	. Was Decedent of If Yes, specify Cub		(Specify Yes	s or No-	14. Race - Ame	erican Indian,	
1	Completed by Funeral	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces?  1 XYes 2 □ No If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 ☑ No		erto Rican, e	itc.)	Black, White	te, etc. Black	
	eted	15. Decedent's Edu (Specify only highest grade		(Giv	edent's Usual Occu e kind of work done DO NOT use retire	during most of w	vorking	16b. F	Kind of Business	/Industry	
	ошо	Elementary/Secondary (0-12) 12th	College (1-4or 5+)		Postal Wo			G	overnme	nt/ Post	t Ofc
	To Be C	17. Father's Name <i>(First, Middle, Last)</i> Herbert Bouk	night	'		18. Mother's N	<sub>lame (First,</sub> nie Al		n Sumame)		
injury or other traumatic event, the Machine Law intermediate		19a. Informant's Name/Relationship (Ty Marsha B. Smith/ 1			ling Address (Stree				or Town, State, 20785	Zip Code)	
		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R	emoval from State	20b. Place of Disc cemetery, cr	position (Name of amatory or other pla	асе) Ос	tober		ocation - City or		
		`4 Donation 5 ☐ Other (Specify)		State	ematory or other pla Veteran Cemetery 22. Name and Addr	2	2009		heltenh		
once		21. Signature of Funeral Service Licens	Dowal	ME	4001 Ber	nning Rd	• NE	Washin	gton, D	c 20019	9
an cal ier	50	23a. Part!! Et ter the diseas or complishook of heart failure. List only or immediate Cause (Final disease or condition resulting in death)	Due to (or as a	consequence of):	AC AR	RHYTHN	114			Approximate Interval Bets Onset and D	ween
1	dical Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):							
	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 \( \begin{array}{c} \text{Yes} & 2 \( \begin{array}{c} \text{No} \\ 9 \end{array} \text{Unknown} \)	3c. If yes, outcome of 1 Live birth 2 4 Pregnant at ti 9 Unknown	Fetal death 3	☐Ectopic pregnan☐ Other (specify)	су			23d. Date of de Month		Year
9	by	Part II. Other significant conditions con	ntributing to death but	not resulting in the	underlying cause g	iven in Part I.	23		use contribute	3.7	death? Únknown
	Completed						-	a. Was an autopsy performed?	death?	autopsy findings completion of c	available ause of
ō	Be	25. Was case referred to medical examiner?	lospital:	- 0	10	26. Place of 0	Death (Chec	k only one)			
=	٦.	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatien  28a. Date of Injury	-	BIIL 3 DOA	4   (4013)11		Residence	6 Other (Sp.	ecify)	
	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	(Month, Day	Year) Injury	M 1[	Yes 2 No			and Number or F	Qurai Pouta Mum	nhae
6	Certifi	4 Homicide determined	building, etc.	(Specify)	street, factory, office	3		y or Town, Sta		TO TO TO THE THE	1001,
	Medical	29a. Certifier (Check only one) Certifying Phy	sician: To the best of ner: On the basis of and manner state	xamination and/or	ath occurred at the investigation, in my	time, date and pla opinion, death o	ace, and due ccurred at th	e to the cause( ne time, date a	(s) and manner a nd place, and du	as stated. ue to the cause(s	5)
completely filled in	×	29b. Signature and title of certifier	e A	•		nse number			ate signed (Mor		
		30. Name and address of person who come add	I LA	, Co.		3688			9-20 1D 2	2-04	
				ath (Item 23a) (Tyn	e Print)		-1				

Jarris Baldwin Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 09-07427 UNK UNK State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death I. Decedent's Name (First, Middle, Last) Physician/ Month Day Y September 22, 2009 0335 hrs **Medical Examiner** BALDWIN **JARVIS** 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Prince George's Bowie S/B 4200 Enterprise Road 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or ForeignSpringfield If Under 1 Year | If Under 24Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min Months Days Hours Country)MA Director  $_{1}X$  M 11/10/1976 2 578-08-9343 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1X Yes 2 No 28a-f show items 23a or 28a-f shoust be notified at once. Temple Hills Maryland Prince George' Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20748 United States 5301 Redd Lane Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. 11. Marital Status altimore, MD 21215-0036
mit. Pages I and 2 should be filed within 72 hours after death will partment of Health and Mental Hygiene.
profund: I friem 27 is marked other than "natural", or items; but ye other traumatic event, the Medical Examiner must be. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes Yes 2 X No specify: Specify: Black Widowed Divorced If Yes, Give Year <u>چ</u> 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Electrician Technician Private 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvern Baldwin Pastora Cuarsema 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 5301 Redd Lane Temple Hills, Maryland 20748 Melvern Baldwin / Father 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9/26/2009 Landover, Maryland Harmony Memorial 4 Donation 5 Other Speqify 22. Name and Address of FacilityPope Funeral Homes, P.A. 21. Signature of Funeral Service Lensee 5538 Marlboro Pike Forestville, Maryland 20747 Approximate Interval Par I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death a. Compressional Asphyxia Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): Examiner cause Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical as been signed by the attending physician 2 should be detached for use as the burial -UNPENDED AMENDED Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? Yes 2 1 🗸 26.Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: funeral director Be Division of Vital Hospital: 1 Other<sub>4</sub> DOA Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes After 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: Driver auto-fixed objet collision 1 FOUND: Natural Yes 2 ✔ No death. Pendina the Director: Sep 22, 2009 0309 hrs 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. a 24 hours after c e Funeral Direc 3 Could not be or Town, State) S/B 4200 Enterprise Road, Bowie, Md. Suicide determined (Specify) Major Road / Highway Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the ! and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie September 22, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Carol Alian, MD 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner 32. Registra 31. Date filed (Month, Day Yea SEP 2 4 2009 s Signatere State Registrar

		1 - For State Registrar	State	ot Marylar	-	artment of F ertificate of		id Mental Hy	'giene Reg. No.	9 32151
Dhoo		1. Decedent's Name (First, Midd	le, Last)					2. Date of De Month		3. Time of Death
Physi /Me	ician dical	K HIMIN BUT H	EUGI	ENE	CLABA	1			BER 15,200	
Exam	niner	4a. Facility Name (If not institution FREDERICK MEMO	_			4b. City, Town, o		eath	4c. County of D	
Funera	al	5. Social Security Number	6. Sex	7. Age (In yrs		If Under 1 Year Months Days		Hrs. 8. Date of Bi	rth 9.	Birthplace (State or Foreign Country)
Directo	or	212-50-9516	1 <b>½</b> M 2 □ F	62	Yrs.	Months Days	Tiours	April	27, Year) 27, 1947	Maryland
land bw It		Usual Residence of Decedent  10a. State 10b. County	/	10c. C	ity, Town or L	ocation				10d. Inside City Limits
Mary a-f sh	to	Maryland Fred	erick		Churmon	nt				XXYes 2 □ No
h with the 23a or 28 st be not	al Director		Street			10f. Zip Code 2178	8		10g. Citizen of What USA	Country?
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Menhall Hygiene.  If Health and Menhall Hygiene.  Them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Examiner must be notified at	by Funeral	3 ☐ Widowed 4 ☐ Divorce	Armed	3 2 □ No Give	J.S. 13	Was Decedent of Introduction	dispanic Origin an, Mexican, P Specify:	r? (Specify Yes or No Puerto Rican, etc.)	Black, W	merican Indian, Thite, etc. white
thin 72 ho le. Medical	Completed	15. Decede (Specify only high: Elementary/Secondary (0-12)	nt's Education est grade completed College	d) (1-4or 5+)	(Give	edent's Usual Occup e kind of work done DO NOT use retire	during most of	f working	16b. Kind of Busine	
ed wi lygien her th			4 0		Cont	ractor	40. 14-45	Name (First Middle	Construc e, Maiden Surname)	ction
2 should be filed within and Mental Hygiene. is marked other than aumatic event, it e.m.	a		, Last)					et Clabau		
should be and Mental s marked o	٢	19a. Informant's Name/Relation	ship (Type. Print)		19b. Mai	ing Address (Street	and Number o	or Rural Route Numi	ber, City or Town, Sta	te, Zip Code)
1 and 2 thealth a tem 27 is		Barbara Clabau	gh - wife						t, Marylar	
permit. Pages 1 an Department of Heal Important: If item 2 any injury or other		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation	2 D Romoval from	20b.	Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce)	Date	20c. Location - City	or Town, State
permit. Pages 1 Department of H Important: If ite any injury or ot		4 □ Donation 5 □ Other (	Specify)	Sta		Cremator		-21-2009		k, Maryland
Depar Mpor mpor	once	21. Signature of Funeral Service	Licensee	//	~	22. Name and Addre	-		Funeral Funera	
4020	<u> </u>	23a. Part1. Enter the disease, of	AULUL TO COMPLICATIONS THA	Coursed the dea						Approximate
Dhamisis		shock, or heart failure. Lis	t only one cause or	each line.			119, 50011 05 00	rado or roopilatory	an oot,	Interval Between Onset and Death
Physicia /Medica		disease or condition resulting in death)	a. Due t	o (or as a conse	guence of):					HOURS
Examine	er	Convention link and distance	h	1	euke	m14-	ERTHAG	POINTE		Years
be sit	iner.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due t	o (or as a conse	quence of):	EMIA- NOV	Hode	KINS		Yearl
cate be executed physician and the burial-transit	Fxaminer	that initiated events resulting in death) Last		o (or as a conse						72
ate be exhysician	dical F			(0. 20 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	<b>1</b>					
tificate g phy as the	Polic		d	-						
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Liv	outcome of pregree birth 2 Peter Feter Fet	tal death 3	☐ Ectopic pregnan☐ Other (specify) _	су		23d. Date of Month	delivery Day Year
that the ped p			ions contributing to	death but not re	sulting in the	underlying cause gi	ven in Part I.	23e. Did	tobacco use contribu	te to the cause of death?
equires t	74 P4							1 🗆	Yes 2□No 3□	Probably 4. Unknown
To the Hospital or Attending Physician: The law requires that the dwithin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached	Completed							24a. Wa auto peri 1 □ Yes	opsy prior deal	e autopsy findings available r to completion of cause of th? Yes 2 \( \sumbole \text{No} \)
ian: '	B o C	25. Was case referred to medic	al				26. Place of	f Death (Check only		100 2 1110
hysic this ce	P	1 Yes 2 No		Inpatient 2		BIIL 3 DOA		1	sidence 6 Other	Specify)
ling P	2	27. Manner of Death  1 Natural 5 Pend	ing (M	te of Injury o <i>nth, Day, Y</i> ea <i>r)</i>	28b. Time Injury	Wo	iryat rk? ]Yes 2 ∐No		how injury occurred	
ttend death ctor: y the 1	ica	2 Accident inves	inot be 28e. Pla	ce of Injury - At I	home, farm, s		IYes Z [ NO		(Street and Number of	or Rural Route Number,
al or / s after al Dire	Certification:	4 ☐ Homicide deter	mined 200. Fla	ilding, etc. (Spec	eify)	treet, factory, office		City or To	own, State)	
e Hospit 124 houn e Funera letely fille	Medical		I Examiner: On the						e cause(s) and mann e, date and place, and	
To th withir To th	M	29b. Signature and title of certifi	er 7 -	2 (/		29c. Licen	se number	162	29d. Date signed (M	fonth, Day, Year)
		<b>)</b>	// '	100	MA	/-	10012	1,25	7 16	, 07
8		30. Name and address of perso	4.4	100	em 23a) (Type	Print)	77	urmon	29d. Date signed (M) 9 16 (M) 213	7-88
	State		r) 32	Registrar's Sign	nature					
Regi		SEF 60	2009	leva ,	13. Age	ENERS.				
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rol Cox	1	State - For State	te of Marylan		tificate of		u Menta		2	009 3215
	B	tegistrar  1. Decedent's Name (First, Middle,)	4\		uncate of	Deaili		2 Date of Dea	teg. No.	3. Time of Death
Physicia edical Examin		Carol Lyr						Month Septemb	Day Year er 26, 2009	0202 hrs
euicai Examin		4a. Facility Name (if not institution,		per)	4	b. City, Town, or	Location of I		4c. County of	f Death
		Carroll Hospital Center	3.70 0.00	,		Westminste	er		Carroll	
Funeral	-		. Sex 7.	Age (In yrs. la	st birthday)	If Under 1 Yea	ar If Under	24Hrs. 8. Date of B	irth(MM/DD/YYYY)	9. Birthplace (State or
Director			1 M 2 <b>X</b> F	39	Yrs.	Months Day	s Hours	Min. Feb 1	, 1970	ForeigrMaryland Country)
		Usual Residence of Decedent								
any		10a. State 10b. County		10c. City,	Town or Location	non				10d. Inside City Limits
nd show	-	Maryland Carro	011			W	estmin			1 Yes 2 No
Maryland 28a-f show any d at once.	Director	10e. Street and Number				10f. Zip Code			10g. Citizen of Wh	
the Na or 2		1626 Old Taneyto	own Road				2115			SA
with ns 23 pe no	Funeral	11. Marital Status	12. Was Deced					n? (Specify Yes or No Puerto Rican, etc.)	lo- 14. Race White	- American Indian, Black, e, etc.
death or ite	اڐ	1 Never Married 2 Mar	1 Yes	2 X No				, ,		white
after	à		rced If Yes, Give Year or Dates:			Yes 2 N		nd of work done	Specify:	
hours	8	15. Decedent's Education (Speci	fy only highest grade  College (1-4		during m	ost of working lif	e. DO NOT u	se retired)	TOD. FAITE OF DE	
36 in 72 han "	틢	Elementary/Secondary (0-12)	3	FOI 5+)	l r	oisabled			l N	/A
with spiene ber the	Completed	17. Father's Name (First, Middle, I				715005100		Name (First, Middle		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the M dica	BeC	Lawrence Kenn	·				Laur	a Livengo	ood	
212 alld b Ment mark		19a. Informant's Name/Relationsh	ip (Type, Print )					oer or Rural Route N		
MD d 2 sho lth and n 27 is		Richard A. Coll	ins, fiand						estminste	er, MD 21158
e, e, l and l and Healt item	Ш	20a. Method of Disposition			Place of Dispos	ition (Name of c	emetery,	Date		- City or Town, State
nor Pages ent of nt: If		1 Burial 2 Cremation 4 Donation 5 Other Spe		Ca	erroll (	Cremator	y	9/29/2009	Winfi	eld, MD
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoo injury or other traumatic event, the M dical Examiner must be notified at once.		21. Signature of Funeral Service L								neral Home
iii iii ji		Justi R. I	Surbon					et, Westmi		
Physician		23a. Part I. Enter the disease, or of the illure. List only one cause of	complications that car on each line.	used the death	n. Do not enter t	he mode of dyin	g, such as ca	rdiac or respiratory	arrest, shock, or ne	Dottioon onder and
/Medical ;aminer		Immediate Cause (Final disease	a. Quetiap			done in	toxica	tion		Death
tairinici		or condition resulting in death)	Due to (or as a	consequence o	of):					
	-	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of	of):					
	ni.	cause. Enter Underlying Cause (Disease or injury that initiated	c							
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o, e be e ysicia buria	edi	IF FEMALE:		3a,27,		ermE, g	89/ 11	/13/09 TT	23d. Date o	of delivery
ceath certificate be est tertificate be unia	In/N	23b. Was decedent pregnant in the past 12 months?				etal death	3 Ectopio	pregnancy	Month	Day Year
OX 6 sath cer attendi	icia	1 Yes 2 No 9 V Unk		ant at time of d	eath 5 0	ther (Specify)				
BC ne dear the a	Physician/Med	Part II. Other significant conditi	9 Olikilo		reculting in the	underlying caus	e given in Pa	art I. 23e. Di	d tobacco use conf	tribute to the cause of death?
i, P.O.	by F	Part II. Other Significant Conditi	ons continuing to	death but not	resulting in the	and any may	<b>. .</b>	1 🗌	Yes 2 ✔ No 3	3 Probably 4 Unknown
rds, Frequires	ted									. Were autopsy findings available
ords, aw requir nas been s	ompleted							pe	itopsy erformed?	prior to completion of cause of death?
Rec The I	Con						15		es 2 No	1 Yes 2 No
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medica examiner?			ER/Outpatier		Other	(Check only one)  Nursing Home 5	Residence 6	Other:
f Vid Physic er this ral dir	ဥ	1 ✓ Yes 2 No 27. Manner of Death	1   1		28b. Time of		njury at Work		be how injury occu	urred
n of hiding Ph. h. After t	<u></u>	1 Natural 5 Pend	28a. Date (Month,		Fd 12:	57 at 1	Yes 2X	No unk		
ivisior  or Attend after death Director:	icat	. TV	200 Place	26/09 e of Injury - At		eet, factory, office	e building, et	tc. 28f. Location	on (Street and Num	nber or Rural Route Number, City
Diviral or results after the control of the control	Certification:	3 Suicide 6 X Coul 4 Homicide dete	a not be I	house				Rd or low	estminst	nber or Rural Route Number, City Old Taneytown er, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burn		29a, Certifier	hysician: To the bes	t of my knowle	edge, death occ	urred at the time	, date and pl	ace, and due to the	cause(s) and mann	ier as stated.
the true of the	Medical	one) 2 ✓ Medical Exa	miner:On the basis of and manners	of examination tated.	and/or investig	ation, in my opir	nion, death o	ccurred at the time, o		d due to the cause(s)
T W M	Me	29b. Signature and title of certific				1	ense number			gned (Month, Day, Year)
		Morganie It	relfull			O.	C.M.E.		Septemb	er 26, 2009
No.		30. Name and address of person					<b>.</b>	ND 04004		
NA		Margarita Korell MD.	Assistant Med			Penn Street	, Baltimor	e, MD 21201		
	tate	OFD 0		egistrar's Signa		backer				
Regis	uat	1 SEP 2	9 7009 4	Lyw-a	Fd	o work				

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ORIGINAL.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** Eugene Anthony Cerreta September 24, 2009 1:25 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Golden Living Center Westminster 8. Date of Birth (Month, Day, Year) July 7, 1924 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1**∑**M 2□F 218-14-2852 85 Yrs. Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County in than "natural", or iteme 23e or 28a-f show the Medical Examinar must be notified at 1X Yes 2 No Maryland Carroll Manchester Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21102 United States 2912 Michelle Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No WW II Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married WW II Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: ģ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Social Security Admin. federal worker 12 traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental I Maria Nestico ie marked Joseph Cerreta ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacob J. Cerreta - son 2912 Michelle Road Manchester, Maryland 21102 Health item 27 i 20b. Place of Disposition (Name of cemetery, crematory or other place) Sept. 25, 2009 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if ite
any njury or oti 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Hampstead, Maryland Carroll Cremation 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licena 22. Name and Address of Facility Eline Funeral Home 934 South Main Street Hampstead, Maryland 21074 M01072 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** onvas disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events certificate be executed use as the burial-transit los Exami Bug resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 Other (specify) P.O. been signed by the s should be detached 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 3 Probably 4 Unknown 1 Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed? Yes 2 No 1 ☐ Yes Division of Vital Physicien: director Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 70 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA After th 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Natural
2 ☐ Accident 5 Pending 1 Yes 2 No death. investigation within 24 hours after death To the Funeral Director:, completely filled in by the f 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö 1 [Kertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Per me, g902,04/30/2010dnb Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** 09 ichael anner unn /Medical 4a. Facility Name (If not institution, give street and number) County of Death 4b. City, Town, or Location of Death Examiner mtcol arro 8. Date of Birth (Month, Day, Y July 21 9. Birthplace Country) 5. Social Security Number (State or Foreign 7. Age (In yrs. last birthday, **Funeral** <sup>Year)</sup> 1952 **↓**□ M 2□ F Months Days Hours Min. 57 VA 225-80-1179 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show Examiner must be notified at Funeral Director 1 ☐ Yes 2 No Carroll Westminster 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō 21157 USA 946 Leisters Church Road or Items 23a Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Š Specify: White 3 Widowed 4 Divorced "natural", Completed d other than "nature event, the Medical 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. Item 27 is marked other than rother traumatic event, The M Bechtel Power Corp Civil Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Doris Crotts M. Edsel Conner မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 946 Leisters Church Road Westminster, MD 21157 Jane Conner/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If its any Injury or o oooce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Leisters Church Cem 9/19/2009 Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Princes Figner Still Home and Chapel, P.A. 21157 412 Washington Road Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Pneumonia Immediate Cause (Final **Physician** 2 Weeks disease or condition resulting in death) /Medical Due to (or a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burlal-transi PROVEDBY MEDICAL EXAMINER resulting in death) Last Due to (or as a consequence of): CERTIFICATION A P.O. Box 68760 attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year signed by the a 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by וֹצְאַ 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown cate has been si page 2 should b 2 No Kutonomic Insufficiency 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Or Pesto his autopsy performed certificate Chronic Paraplegia due to Astrocytoma 1 ☐ Yes 2 No 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient 2 ER/Outpatient 3 DOA Certification: To After this nours after death.

neral Director: After this
filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide e Funeral I certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number H53939

State Registrar

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218 washing In Heights Med Ctr; Westminster

21157

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Babak Imanoel.

31. Date filed (Month, Day, Year)

		1 - For State Registrar			Ce	rtificate of	Death			Reg. No.	20	nā	3215
sici	an	1. Decedent's Name (First, Middle	, ,				•		2. Date of Dea Month	Day	·	Year	3. Time of Death
edic		Altha Mar		land		T			Sept				17:20
min	er	4a. Facility Name (If not institution Anne Arundel Me				4b. City, Town, o		of Death			County of Anne		ındel
ral	_	5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday,	If Under 1 Year	If Under		8. Date of Birt (Month, Da	th V Year)		9. Birth	place (State or Forei
tor		579-18-8693	1 □ M 2 <b>/(_)</b> F	88	Yrs.	Months Days	Hours	Min.	Oct. 3	0,19	20		shington D
d		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or L	ocation					_		10d. Inside City Limi
· The little	tor	Maryland Anne	e Arundel	Ar	napol	is							1 □Yes 2 □ N
	Direc	10e. Street and Number				10f. Zip Code	^			-	izen of W	hat Cou	ntry?
TISIT.	<b>Funeral Director</b>	84 Old Mil			2 142	2140			N		ISA		!!:
100	Fune	11. Marital Status 1 ☐ Never Married 2 🏋 Marr	Armed Fo	edent Ever in U. orces? 2 📉 No	S. 13.	Was Decedent of F If Yes, specity Cub	an, Mexicai	n, Puerto	Rican, etc.)	-		- Ameri , White,	can Indian, etc.
a de la composition della comp	Ď	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or D	ive **		1 □ Yes 2 😾 No	Specify.	:			Specify:		White
Circai	Completed	15. Decedent (Specify only highes	t's Education st grade completed)	)	(Give	edent's Usual Occup kind of work done	during mos	st of worki	ng	16b. Ki	ind of Bus	siness/Ir	ndustry
200	dmc	Elementary/Secondary (0-12)	College (	1-4or 5+)		DO NOT use retire emaker	a)				Do	mest	tic
i i	Be	17. Father's Name (First, Middle,	Last)				18. Moth	er's Name	(First, Middle,	Maiden	Surname	e)	
1	TO E	William Jo	ohnston	Frain				Jenn	ie May		)isne	y	
any njuly or other traditions event, the recipied Express 1 up the religion once.		19a. Informant's Name/Relations		L J		ing Address (Street							p <i>Code)</i> olis,MD 21
		Peter Cle.  20a. Method of Disposition	land- Hus			osition (Name of matory or other pla			ate Apt.				own, State
5		1 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S		State		matory or other pla Veteran '	i	Sent	.22,200	9	Che	1te	nham, MD
ce de		21. Signature of Fuperal Service		M0153	3 2	2. Name and Addre	ess of Facili	ity L	ee Fune	ral	Home	e, I1	nc.
§ 8		7 tune	m. 5	-							C1in	ton	, MD 20735
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that only one cause or	caused the deat each line.	h. Do not er	iter the mode of dyi	ng, such as	s cardiac o	or respiratory a	rrest,			Approximate Interval Between Onset and Death
an cal		Immediate Cause (Final disease or condition resulting in death)	a	Den	rente	٩						1	unknown
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	xamine	Cause (Disease or injury that initiated events resulting in death) Last	C	(or as a conseq	nence of).								
9	alE			(or do a conceq	donoc ony.								
	ledic		d			-							
	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		utcome of pregna		☐ Ectopic pregnan	су				23d. Date		very Day Year
	/sici	1 ☐ Yes 2 MNo 9 ☐ Unknown	4☐ Preg 9☐ Unk	gnant at time of one community of the co	death 5	Other (specify) _					WO		Day Tour
		Part II. Other significant condition	ons contributing to d	death but not res	ulting in the	underlying cause gi	ven in Part	I.	23e. Did t	obacco	use contri	ibute to	the cause of death?
2	ed by								1 🗆 '	Yes 2	□No	3 ☐ Pro	bably 4 Unknow
5	Completed								24a. Was		24b. V	Vere aut	opsy findings availat
n n i	Com								perfo 1 □ Yes	rmed?	d	eath?	2 🗆 No
	Be	25. Was case referred to medical examiner?	Hospital:			Oti	her:		n (Check only o				
	7: <b>1</b> 0	1 ☐ Yes 2 No 27. Manner of Death	28a. Date	e of Injury	28b. Time	of 28c. Inju	ıry at		me 5 Resi			. ,	ify)
5	atio	1 X Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	nth, Day, Year)	Injury	M 1 E	rk? ]Yes 2.□	]No					
, and a	Certification:	3 □ Suicide 6 □ Could i 4 □ Homicide determ	28e. Plac	e of Injury - At he ding, etc. <i>(Sp</i> ec <i>i</i>	ome, farm, s	reet, factory, office			28f. Location ( City or To			er or Rui	ral Route Number,
		29a. Certifier Certifyir	ng Physician: To th	ne best of my kno	owledge, dea	th occurred at the	time, date a	and place,	and due to the	cause(s	s) and ma	nner as	stated.
	Medical	(Check only 2 Medical one)	Examiner: On the and mai	basis of examina nner stated.	ation and/or i	nvestigation, in my	opinion, de	ath occur	red at the time,	date an	d place, a	and due	to the cause(s)
pietery med		29b. Signature and title of certifie	r	410		nvestigation, in my 29c. Licen D, Print) Q Violet	se number	15	34	29d. Da	ate signed	2 1 2	, Day, Year) 2009
כטוויף מנפין ווווסט ווו טל מום ומוסטים, ף בשפר ב אוטמום טס מפומטופט וטו משפר בא נווס סטומ	2	I receive the	reman	(1000)			000				- 11	1	

State Registrar

			1 _ State	· ·	artment of Health and rtificate of Death		_ 21110	32155
			Registrar  1. Decedent's Name (First, Middle, Last)		Tillicale of Dealif	Reg.	No. 1 0 0 0	3. Time of Death
	Physici	an	Jacqueline B. Colema	an			Day Year	
de.	/Medio		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Dea		8 2009 4c. County of Death	1018 M
	Examir	ıer	Period to Period of the	dical Can had	50 1:51 150		Wicom	ico
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Ars	8. Date of Birth	9. Birth	place (State or Foreign
	Director		221-34-7982 1□M 2√x	F 75 Yrs.	Months Days Hours Min	. (Month, Day, Ye. 3-3-1934	ar) Coul Mary	
	P.		Usual Residence of Decedent					
	show	_	10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	8a-f	Director	DE Sussex	Laurel				1 ☐ Yes 2√ No
	vith th	ā	100.72 Manual 1 Design		10f. Zip Code	10g.	Citizen of What Coul	ntry?
	s 238	eral	10073 Marvil Drive		19956		USA	
	hin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Madisal Evaninar must be nutfied at	Funeral	Arme	Decedent Ever in U.S. 13. d Forces?	Was Decedent of Hispanic Origin? ( If Yes, specify Cuban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	14. Race - Ameri Black, White,	
21215-0036	rs aft	by F	I If Yes	es 2 No , GiveA or Dates:	1 □Yes 💥 No <i>Specify:</i>		Specify: Wh	ite
ŏ	2 hou	ted	15. Decedent's Education	16a. Dece	dent's Usual Occupation	16b	. Kind of Business/In	dustry
215	in 72	Completed	(Specify only highest grade complete	(Give life,	kind of work done during most of wo DO NOT use retired)	orking		
21	Jen H	ĕ	Elementary/Secondary (0-12) Colleg	ge (1-40) 0+)	Homemaker		Home	
pu	0 - 0 9	Be C	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid	den Surname)	
/la	should be f nd Mental marked o imatic eve	2	Unknown		Muria	L Bachlor		
Maryland	2 should and Men is marke aumatic	ľ	19a. Informant's Name/Relationship (Type. Print)	19b. Mailii	ng Address (Street and Number or F		ty or Town, State, Zi	o Code)
	s 1 and 2 should of Health and Mer item 27 is marke other traumatic		Burton Coleman (husba		Marvil Drive Lau			
altimore,			20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal fr	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date 20c	. Location - City or To	own, State
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alt	permit. Page Department of Important: If any injury or once.	Ιĝ	21. Signature of Funeral Service Licensee	. 2	2. Name and Address of Facility 00 West St. T	nnigan Shor	t Disharo	on F.H.
<u>B</u>	90 E # 9		Dolly Short-d	Jannegan 1	00 West St. Lau	rel, Delaw	are 19956	
			23a. Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause	nat caused the death. Do not entone	ter the mode of dying, such as cardia	ac or respiratory arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	mencardic	1 interchin		19	Onset and Death
	/Medical		resulting in death)	e to (or as a consequence of):				
	Examiner	L	Sequentially list conditions.					
4	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	e to (or as a consequence of):				
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8760,	cate be executed physician and the burial-transit		, Due	s to (or as a consequence or),				
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Вох	eath atter for u	cjan	in the past 12 months?	ive birth 2 Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)		Month Month	Day Year
		ıysjı		Jnknown				
σ.	res that the signed by th be detache		Part II. Other significant conditions contributing	to death but not resulting in the u	nderlying cause given in Part I.	23e. Did tobac	co use contribute to	the cause of death?
Vital Records,	requires sen sign hould be	d by	cerebrovascular	accident		1 ☐ Yes	2. No 3 □ Pro	bably 4 🗌 Unknown
00	- M (0	lete	diabetes mellit			24a. Was an	24b. Were aut	opsy findings available
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<u>ra</u>	ician: Th certificate ector, pag		25. Was case referred to medical	willation	00 Pl (P	1 Yes 2	No 1 □Yes	2 No
5		o Be	examiner?	□ Impatient 2 □ ER/Outpatie	Other:	eath (Check only one) Home 5  Residence	a 6 DOthor (Sans	56.A
of	y Phys er this eral dii	ij	27. Manner of Death 28a. D	Date of Injury 28b. Time o		28d. Describe how in		iiy)
on	tth. : Afte	ţ	1	Month, Day, Year) Injury	Work? M 1 □ Yes 2 □ No			
Division of	Attending r death. ector: After by the fune	ij	a Cloude and he	l lace of Injury - At home, farm, str uilding, etc. <i>(Specify)</i>	reet, factory, office	28f. Location (Stree	t and Number or Rui	al Route Number,
Ö	al or s afte	Certification: To	4 ☐ Homicide determined b	uliding, etc. (Spechy)		City or Town, S	tate)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral		29a. Certifier  1 Certifying Physician: To Medical Examiner: On t	o the best of my knowledge, deat	h occurred at the time, date and plan	ce, and due to the caus	se(s) and manner as	stated.
	he Ho in 24 he Fu plete	Medical		ne basis of examination and/or in manner stated.	vestigation, in my opinion, death occ	curred at the time, date	and place, and due	to the cause(s)
	Vithi To th	Σ	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month)	Day, Year)
			( Land		030853		9/18/00	1
		12	30. Name and address of person who completed			1	616	1//
	lok		Charles B. Silvia	JV mys 1	Enmula Region	al Medical	(extr )	ulisbuy was
	Sta Registr		31. Date filed (Month, Day, Year) 3	2. Registrar's Signature	1			1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 10 /Medical 4c. County of Death Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner If Under 24 Hrs. Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 🗹 F Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d, Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 No Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 211 14. Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 2 No 1 ☐ Never Married 2 Married Specify: 4 2 No 1 🗆 Yes Baltimore, Maryland 21215-0036 Completed by JAITE 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be RIDGEL ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State,

Date

20c. Location - City or Company or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) 260 MOUNTAIN RD. PASADENA, MD. Z1122 Approximate Interval Between Onset and Death aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part1. Enter the disease shock, or heart failure. ase, or complications that caused the List only one cause on each line. Immediate Cause (Final elad oukenuc Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed use as the burlat-tran and Due to (or as a consequence of): After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burlal Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1∐ Yes or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 Yes 2 No Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 3□ DOA Certification: To 1 Inpatient 2 ER/Outpatient Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation death. after death the 1 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours To the Funeral 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated.

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

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31. Date filed (Month,

allee

30. Name and address of person who completed, cause of death (Item 23a) (Type, Print)

Registrar's Signatu

Kawai

20, crossroads

29c. License number D2511 29d. Date signed (Month, Day, Year)

Jungs Mell

Suite101

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Sep 29, 2009 **Physician** 8:46am M Cuppett /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Cumberland Allegany Devlin Manor Nursing Home Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Apr 7, 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours 1 □ M 2 □ ₽ 215-26-6458 79 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Cumberland MD Allegany 1 ☐Yes 2 ☐ No Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 10301 Christie Road Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 □Yes 2□No Baltimore, Maryland 21215-0036 and Mental Hygiene. Specify: Completed by white 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade com (Give kind of work done during most of working life. DO NOT use retired) grade completed) Elementary/Secondary (0-12) College (1-4or 5+) homemaker own home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Angwin McFarland Samuel McFarland ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print, MD 21502 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau 10705 Christie Road NE Charlotte Lippold daughtei Cumberland 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Rocky Gap Veterans Cemetery 10/2/2009 MD Flintstone 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Scruce Lonnsee 22. Name and Address of Facility ral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 rations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest cause on each line. Approximate Interval Between Onset and Death 23a. Part / Enter the disease, shock, or heart failuh. L Immediate Cau. / Final disease or con ition resulting in de. (1) Carcinoma **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician ar s the burial-to Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 Z No 9 ☐ Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ρ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed? Yes 2 WNo 1 TYes 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No after death.

I Director: A
id in by the fu investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only one) 2N Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A

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.m.r

32. Registrar's Signature

DHMH 17 Rev 1/2001

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29c. License number

00033280

Kent Are. cumb, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year Month Audrey Davis **Physician** 12:45A 20 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number)
WASHINGTON Adventist Hospital 4b. City, Town, or Location of Death Examiner Montgomery Takoma Park Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday, 5. Social Security Number 6. Sex **Funeral** Days Hours Months S.C. 1 □ M 2 🖫 F 579-56-7455 66 Director -5-1943 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Items 23a or 28a-f show important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wedical Examination is be notified at once. 1 ☐ Yes 2 ▼ No rector Hyattsville P.G. MD 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 20782 U.S.A. 5415 16th Ave. Apt#T2 Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: Black 1 □Yes 2 XNo Specify: Baltimore, Maryland 21215-0036 Yes. Give δ Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha Moore Edward Washington ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5415 16th Ave Hyattville MD. 20782 Richard Davis Sr. (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood MD. 9-26-2009 Lincoln Cem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hunt\_Funeral Home D.C.20011 908 Kennedy St. N.W. Wash, Tlun Trances Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine physician and s the burial-trans Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending ph for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 🗷 No 5 Other (specify) 9 Unknown cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 200 No 2 No 1 ☐ Yes certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1∐ Yes Certification: To 28d. Describe how injury occurred 28b. Time of 27, Mannu

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, funeral director, After iours after death.

neral Director; A
filled in by the fu death. To the Hospital within 24 hours a To the Funeral D

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 = ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier address of person who completed cause of death (Item 23a) (Type, Print).

State Registrar

Medical

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar		,	Certifi	icate of	Death		,	Reg. No.	2001	9	321	159
	- · · ·		1. Decedent's Name (First, Middle, I	_ast)	· · · · · · · · · · · · · · · · · · ·					2. Date of De Month	ath Day	Year	3.	Time of D	eath
	Physici /Medio		MARY	C	DORS	EY				Octobe		, 2009		3 00 .	ДМ
2	Examin	er	4a. Facility Name (If not institution, g	ive street and number)		4b.	. City, Town, or	Location	of Death		4c.	County of Deat	th		
			Frederick Memor			hadayy) If	Freder Under 1 Year		r 24 Hrs. T	Doto of Bir	th.	Freder		/Ctoto ==	Familian
H	Funeral Director		213-16-0450		(In yrs, last birti		onths Days	Hours	Min.	8. Date of Bir Month Da June 22,	1922 1922	Mar.	untry) ylanc	(State or I	Foreign
	and		Usual Residence of Decedent  10a. State 10b. County	11	Oc. City, Town	or Location	n						10d. I	nside City	Limits
	Maryl	tor	Maryland Fred	erick			Freder	ick					1	Yes 2	2 □ No
	with the a or 28a	Director	10e. Street and Number 112 Clark Place			11	Of. Zip Code	2170:	1		0	zen of What Co	,		
	ns 23	Funeral	11. Marital Status	12. Was Decedent Eve	er in U.S.	13. Was	Decedent of H	ispanic O	riain? (Spe	cifv Yes or No	ı- 1	14. Race - Ame	erican Ir	ndian.	
920	hould be filed within 72 hours after death with the Maryland and Mental Hygiene. Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marke event, the Modified Examination of the modified at	by	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates:			Decedent of H s, specify Cuba ∕es 2 ☑ No	n, Mexica Specify		Rican, etc.)		Black, White			
2-0	72 ho	eted	15. Decedent's (Specify only highest of	Education	16a.	Decedent's	s Usual Occup	ation	st of workin	a	16b. Kir	nd of Business/	Industr	y	
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N	filed w Hygier other th	S	17. Father's Name (First, Middle, La	et)		nouse	Parent	18 Moth	ar'e Name	(First. Middle			.011		
Maryland 21215-0036	ould be f Mental I arked or atic eve	To Be	William Joseph H							izabeth					
, Mar	and 2 sho ealth and n 27 is m		19a. Informant's Name/Relationship William A. Larkin /		11	701 Li	lac Plac	e, Ne			-	r Town, State, 2 21774	Zip Coa	(e)	
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or other traumatic et once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Control of		20b. Place of cemeters Mount (	Disposition , cremator Dlivet	(Name of ry or other place Cemeter)	re) 7	Octobe:	r 5,		cation - City or			
Balt	permit. Departi Import. any inj		21. Signature of Funeral Selvice by	ense e	MO1433	22. Na Keen 106	me and Addres ey & Bas East Chu	ss of Faci ford l rch St	P.A. Fu	meral Ho Frederio	ome ck. Ma	aryland 2	1701		
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wi <sub>e</sub> F	hysician		Immediate Cause (Final disease or condition	- ATRIA	IL FI	BRI	LLATA	TON					Ons	set and De	eath
1	/Medical Examiner		resulting in death)	Due to (or as a c		,	1169	2 4 2	0:10						
		ē	Sequentially list conditions,	b. FNTRA  Due to (or as a co			METT	OJEK	CHIIO						
	uted d ansit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		<b>-</b>	-,-						W.			
Ď.	certificate be executed adding physician and ise as the burial-transit		resulting in death) Last	Due to (or as a c	consequence o	f):			<u> </u>						
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ň į	death e atter d for L	Physician/	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome of 1 ☐ Live birth 2 [ 4 ☐ Pregnant at tir 9 ☐ Unknown	☐ Fetal death		opic pregnanc ner <i>(specify)</i>	у			2	23d. Date of de Month	livery Day	Ye	ar
ກຸ່. ກຸ	requires that the been signed by th hould be detache	by Pr	Part II. Other significant conditions	•	not resulting in	the underl	ying cause give	en in Part	l.	23e. Did t	obacco u	se contribute to			
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Hec	m	Completed								24a. Was autor perfo 1 ∐Yes	osy rmed?	24b. Were au prior to death? 1 □ Yes	comple	tion of cau	/ailable use of
VITal	rnysician: r this certific ral director,	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	•		Oth	or:		(Check only o					
6	g Fny er this eral di	i,T	27. Manner of Death	28a. Date of Injury	2 ER/Out 28b. T	ime of	28c. Injur	4 📖 🗅		ne 5∐ Resi 8d. Describe∃		Other (Spe	ecify)		
0 1	ath. r: Afte e fun	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigati	(Month, Day, Y	<i>(ear)</i> In	jury N		k? Yes 2.□	]No						
DIVISION	to the hospital or Attending Prysician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page.	Certification: To	3 Suicide 6 Could not determine		- At home, fari (Specify)	m, street, f	actory, office		2	8f. Location (: City or To	Street and wn, State)	d Number or Ri	ural Roi	ıte Numbe	er,
	e nospira 124 hours e Funera iletely fille	Medical (	29a. Certifier 1 ☐ Certifying (Check only one) 2 ☐ Medical Ex	Physician: To the best of aminer: On the basis of each and manner state	xamination and	death occid/or investi	curred at the tir gation, in my o	me, date a pinion, de	and place, a	and due to the ed at the time,	cause(s) date and	and manner a place, and due	s stated to the	I. cause(s)	-
	vithir To th	Me	29b. Signature and title of certifier				29c. Licens					e signed (Mont		Year)	
C			Inhle M	D			200	634	198		10	0/1/0	9		
			30. Name and address of person wh	o completed cause of deal	,			Street	t, Fred	lerick, M	aryla	and 21701			
	Sta		31. Date filed (Month, Da	7 2009 Regisar's		d. A	hard	0							
	Registr	ar 💮			€	34									

27

		L_ State	Department of Health and Certificate of Death		iene eg. No. 🥠 🗇	0 00166
		Registrar  1. Decedent's Name (First, Middle, Last)	Corumouto of Dodain	2. Date of Deat		3. Time of Death
Physic /Medi		Emory G. Evans		Septemb		
Exami		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea	ath	4c. County of D	
		Holy Cross Hospital	Silver Spring  irthday)   If Under 1 Year   If Under 24 Hi	's 0 Date of Birth	Montgom	ery Birthplace <i>(State or Foreign</i>
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bi	Yrs. Months Days Hours Mi		928 R	Country) Lichmond VA
9		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow	vn or Location			10d. Inside City Limits
faryla shov	ō	7.	sville			1 □ Yes 2√√No
the N	rect	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What	Country?
3a or	a Di	12910 Forestview Drive	20705		USA	
ire, Maryland 21215-UU36 s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene, item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Extrainant be notified at	by Funeral Director	11. Marital Status  1 ☐ Never Married  2 ☐ Married  1 ☐ Never Married  2 ☐ Married  1 ☐ Was Decedent Ever in U.S.  Armed Forces?  1 ☐ X es 2 ☐ No WWII  If Yes, Give  Year or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pur 1 □ Yes 2 ☒No Specify:	(Specify Yes or No- erto Rican, etc.)		American Indian, /hite, etc. White
27215-UU36 d within 72 hours aff giene. r than "natural", or the Medical Exerci-	Completed b	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)		16b. Kind of Busine	ess/Industry
within piene.	шо	Elementary/Secondary (0-12)  College (1-4or 5+) 5+  F	Professor		Univers	ity
aryland 2 should be filed v and Mental Hygie s marked other i	Be C	17. Father's Name (First, Middle, Last)	į.	ame (First, Middle, i	_	
ylal Suld b Ment arked	2	Wallace Evans		t Strickl		An Zin Codol
Mar d 2 sho lith and it is mo			9b. Mailing Address (Street and Number or 12910 Forestview Dri			
altimore, Maryland rmit. Pages 1 and 2 should be file spartment of Health and Mental Hy portant: If ftem 27 is marked oth y injury or other traumatic event y injury.		20a. Method of Dispesition  1 Burial 2 Cremation 3 Removal from State  4 Donation 5 Other (Specify)	of Disposition (Name of tery, crematory or other place) politan Crematory 9/	Date / 22/09	20c. Location - City Alexandr	•
Baltimor permit. Pages Department of Important: If its any injury or o		21. Signature of Fun, al pervice Licensee	Advent Funeral & Falls Church VA a	Cremation		3
ficate be executed  Wedgical Examiner  physician and s the burial-transit		23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of the conditions) of the conditions of th	e of):	34.1		Interval Between Onset and Death
Box ( sath certi attending for use a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death			23d. Date of Month	
ds, P.O.  Jires that the de signed by the a d be detached	þ	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause given in Part I.			ute to the cause of death?  Probably 4 1 Unknown
Division of Vital Record I or Attending Physician: The law require after death. Director: After this certificate has been si d in by the funeral director, page 2 should I	Completed			24a. Was autop perfor 1 □ Yes	prior prior prior dea	re autopsy findings available or to completion of cause of th?  Yes 2 □ No
/ita	Be (	25. Was case referred to medical examiner?	Othor	Death (Check only o		
vision of Vital Ratending Physician: The rideath. ector: After this certificate he by the funeral director, page		17⊈Natural 5 ☐ Pending (Month, Day, Year)	Outpatient 3 □ DOA	g Home 5 Resid	dence 6 Other	
Divisir To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Certification: To	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, building, etc. (Specify)		28f. Location (S City or Tox		or Rural Route Number,
Div To the Hospital or A within 24 hours after To the Funeral Direct completely filled in by	Medical C	29a. Certifier (Check only one)  12 CertifyIng Physician: To the best of my knowled 2 Medical Examiner: On the basis of examination and manner stated.	dge, death occurred at the time, date and p and/or investigation, in my opinion, death of	lace, and due to the occurred at the time,	cause(s) and mani date and place, an	ner as stated. d due to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (	_
10		I bust a Buyu MI	037840	) 6	eptember	21,2009
		30. Name and address of person who completed cause of death (Item 23:	a) (Type, Print) rnwood Rd #100A, Bet	hesda MD	20817	
2	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature		nesua fil		
Regis		SEP 24 2009 Papers A.	backer			

				1 - For State Registrar	State of Maryla			it of Heal e of Dea		lental Hy	giene Reg. No.	2000	32161
		Physici /Medi		1. Decedent's Name (First, Middle, Last) Mamie Margine Ell						2. Date of De 09-22-		Year	3. Time of Death 13:39 PM
		Examir		4a. Facility Name (It not institution, give s Harford Memorial H				Town, or Loca re de C				County of Deat Nord	h
		Funeral Director		5. Social Security Number 6. Sec. 211-20-2783	7. Age (In yrs	. last birthday) Yrs.	If Unde Months		nder 24 Hrs. ours Min.	8. Date of Bir 11-22-	T. 999	9. Birt Ten	nplace (State or Foreign untry) USSEE
		Maryland -I ehow	tor	Usual Residence of Decedent  10a. State 10b. County Maryland Harford	10c. C	ity, Town or Lo aure de	cation Grac	ee e					10d. Inside City Limits 1 X Yes 2 □ No
		with the Maryla 3a or 28a-f ehov	I Direct	100. Street and Number 505 Congress Avenu	ie Apt. 507		10f. Zip	Code 1078				izen of What Co 2d State	untry? s of America
~	36	filed within 72 hours after death with the Maryland Hygiene. ither than "natural", or Items 23a or 28a-1 show int, the Madical Examiner must be notified at	To Be Completed by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☐ Widowed 4 🏋 Divorced	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Dece f Yes, spe 1  Yes		ic Origin? (Spenican, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White Specify: White	e, etc.
3:39	21215-0036	ithin 72 hou Je. han "natural Madical E	npleted t	15. Decedent's Edu (Specify only highest grade	cation	(Give	kind of wo	al Occupation ork done during se retired)	most of work	ing		ind of Business/	Industry
		e d la b	o Be Cor	17. Father's Name (First, Middle, Last) John May	-	saces			Mother's Name	e (First, Middle Y	l		
601	Maryland	nd 2 sh lith and 27 ie m r treum	-	19a. Informant's Name/Relationship (Ty Wilma Goll (daught		19b. Mailir 222 S	ng Address • Was	(Street and N hingto	n St. H	al Route Numb	өг, City o e Gri	r Town, State, 2 2Ce, Ma	Tip Code) Lyland 21078
1/22/09	Baltimore,	permit. Pages 1 el Department of Hee Important: if item any injury or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State An	Place of Dispo cometery, cror gel Hil	natory or o	netery	09-28		Havr		ace, Marylan
-	Balt	Depart Import		21. Signature of Funeral Service Ligans	11	12	3 S	washing	iton St	Havre	de G		., P.A. 21073 Jaryland
	}	Physician /Medical		23a. Part1. Enter the asease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	CARDIO	GENIC				or respiratory a	rrest,		Approximate Interval Between Onset and Death 2 H NOV S
	68760,	ate be executed by sicien and he burial-transit	dical Examiner	Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse  Due to (or as a conse  Due to (or as a conse	Quence of):	2 7	ACNY	CARO	IIA			24 hours
3111	P.O. Box 6	ne daath certific the ettending p thed for use as	by Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of pregr 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	tal death 3	Ectopic p Other (sp					23d. Date of del Month	ivery Day Year
, MAMI		quires thet the signed by ald be detacted		Part II. Other significant conditions cor	ntributing to death but not re	sulting in the u	nderlying o	ause given in	Part I.		tobacco u		the cause of death?
LLIOTT	of Vital Records,	ician: The law requir certificete has been s rector, page 2 should	Completed		× • • • • • • • • • • • • • • • • • • •					24a. Was auto perfo 1 Yes		prior to death?	ntopsy findings available completion of cause of
TT	/ Vit	Physician: this certific al director.	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	lospital: 1  Inpatient 2	☐ ER/Outpatier	nt 3□ D0	Other		h <i>Check only</i> me 5 ☐ Resi		6 □Other (Spe	cify)
w		Attending Phyrideath.  sctor: After thing the funeral	atlon: T	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injury at Work?		28d. Describe			
	Division	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At I building, etc. (Spec	home, farm, str	eet, factor	y, office		28f. Location ( City or To			ıral Route Number,
		Hospi 24 hours Funer stely fill	edical	29a. Certifier 1 Certifying Physical Check only one)	sician: To the best of my kn ner: On the basis of examin and manner stated.	nowledge, death nation and/or in	n occurred vestigation	at the time, da , in my opinior	ate and place, n, death occur	and due to the red at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)
		To the within :	Med	29b. Signature and title of certifies	)		29	c. License nun	nber		29d. Da	te signed (Mont	h, Day, Year)
				NWZ					6291			22-2	
				30. Name and address of person who co	mpleted cause of death (Ite	om 23a) (Type,	Print)	1 AUG	HAI	re de la	TPAI	P.MA	21078
		Sta Registi		31. Date filed (Month, Day, Year)	32. Hanister's Sign	nature	7	7	, 1///	- W-C	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	-1.10	, v

onnie	Marlene	Farling	

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linear .	Same?	-0.7	-	1	la de	ě.	1	-

	1- For State Registrar			Cert	tificate of	Death					eg. No.	lines h	
Physician/ ledical Examine	1. Decedent's Name	(First, Middle,Last) Marlene	Fari	ling						Date of Dea Month Septembe	Day er 15, 20		3. Time of Death 0115 hrs
	4a. Facility Name (if r		treet and numb	er)		4b. City, Town Oakland	, or Loc	cation of E	Death		Gar	ounty of De rett	atn
Funeral	5. Social Security Nu		7.	Age (In yrs. la	ist birthday)	If Under 1	_	If Under 2		8. Date of Bi	rth (MM/DD		Birthplace (State or reign
Director	234-58-05	61 1 <sub>0</sub> N	1 2 <u>X</u> F	89	Yrs		Days	Hours	Min.	June	6 192	0	Country) Virginia
nore, MD 21215-0036 ages 1 and 2 should be filed within 72 hours after death with the Maryland nt of Health and Mental Higher than "natural", or items 23a or 28a-f show any other traumatic event, the Medical Examiner must be notified at once. TO Be Computed by Ermanal Director	MD  10e. Street and Num  1113 Mary  11. Marital Status  1 Never Married  3 XWidowed  15. Decedent's Edu  Elementary/Secon	Garrett ber Drive  1 2 Married 4 Divorced If	12. Was Deced Armed Ford 1 Yes Yas, Give Year or Dates:	Oallent Ever in Uses? No	1 1 16a. Deceder	10f. Zip Coo 21 des Decedent of des, specify Co	f Hispar uban, M No s	Mexican, F specify: n (Give kir	d of wo	cify Yes or N tican, etc.)	Sp	d Sta Race - Ar White, etc	ntes nerican Indian, Black, c.
5-0036 ed within 7; tygiene. other than the Medical	3				Aid							itari	Lum
5-0 iled wi Hygie I other	)   1111 daner o riame (i				-		18.			First, Middle	, Maiden Su	rname)	
21215-0036 Muld be filed within 7 Mental Hygiene. marked other than c event, the Medica			Thomas		19b. Mailin	a Address (	Street a			rence aral Route No	umber, City	or Town, S	itate, Zip Code)
Baltimore, MD 21215-003 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If iten 27 is marked other training or other traumatic event, the Med To Rock of the Med To Rock other traumatic event, the Med To Rock other traumatic events and the Med To Rock other events and th	Rosetta V			er							aklan	d. MI	21550
e, N 1 and 1 Health Health item	20a. Method of Disp	osition	_	20b. 1	Place of Dispo	sition (Name o				Date	20c. Lo	cation - Cit	y or Town, State
Baltimore, Department of He Important: If ite		Cremation 3 Other Specify:	Removal fror	ii State	•		nato	ory	9/1	6/2009	Cum	ber1a	and, MD
Baltil permit. Departm Importa	21. Signature of Fun	eral Service License	ee .		22.	Name and Ad	dress of	f Facility Burd c	ck	Funera	1 Hom	e, P.	.A.
	Rathur 23a. Part I. Enter the	ine Su	ethy	sed the death	- 0	21 N 9	Seco	and S	: t	()akla	ınd. M	D 715	Approximate Interval
Physician /Medical caminer	failure. List only  Immediate Cause (For condition resulting	y one cause on eacl Final disease a.H	lypertensive	e Atherosci	erotic Card								Between Onset and Death
execut an and al - tra	Sequentially list con if any, leading to im cause. Enter Under (Disease or injury the events resulting in during the control of the control o	mediate Didustrying Cause at initiated leath) Last D	ue to (or as a cue to (or as a coefficient)	consequence o	f):	per ME	g89	06 10	/13	/09 TT			
760, ficate be ex	IF FEMALE:		23c. If yes, or	utcome of preg	nancy							Date of de	-
ox 68 ath certif attending or use as	IF FEMALE: 23b. Was decedent past 12 months?  1 Yes 2 N  Part II. Other signif	?		th nt at time of de		etal death Other (Specify		Ectopic	pregnai	ncy	^	<b>fonth</b>	Day Year
P.O. Bc		icant conditions	contributing to	death but not r	resulting in the	underlying ca	use giv	en in Par	t I.				te to the cause of death?
b, P.O.	left a	arm (hune	rus) fr	acture									Probably 4 Unknown
cords, law requin											as an topsy rform <u>ed</u> ?	pric	re autopsy findings available or to completion of cause of ath?
Recc The lav									_	1 ✔ Ye			Yes 2 No
tal Rec	25. Was case referr examiner?		ospital:		ER/Outpatie		10	of Death ( Other		only one) g Home 5	Residen	ce 6 🗸	Other: Scene
of Vi	27 Manner of Death	2 No	28a. Date o	patient 2 of Injury	28b. Time of		`	at Work		28d. Describ		_	
ion of tending Pheath.  In After the funeral	Natural	5 Pending	9/14/		1500 h	rs.	I Y€	es 2 <b>X</b>	No	subjec			
Division of Vital Records, tal or Attending Physician: The law requints after death.  al Director: After this certificate has been sited by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Natural	Investigation  6 Could not b	28e. Place	of Injury - At h		eet, factory, o	ffice bu	ilding, etc	э.	28f. Locatio or Towr	n (Street an n, State)	d Number 3 Ma	or Rural Route Number, City
Divis Hospital or A 24 hours after Funeral Dire	4 Homicide	determined		Nursin						<u>Oakla</u>	nd, M	D	
To the Hospital within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) 2	Certifying Physicia Medical Examiner:	On the basis o	f examination	dge, death occ and/or investig	urred at the till ation, in my o	me, dat pinion,	e and pia death oc	ce, and curred a	t the time, da	ate and plac	e, and due	e to the cause(s)
To the within To the comple	29b. Signature and		and manner st	ated.				number					(Month, Day, Year)
	1//	1. 14.	Kind.	TR. L	n. )		O.C.N	Λ.E.	0	CME	Sept	ember 1	15, 2009
50	)	ess of person who col. King, Jr., MD.		e of death (Iter nt Medical		111 Per	n Stre	eet, Ba	Itimor	e, MD 212	201		
Sta	Tate 31. Date filed (Month, Day, Year) 32. Registrar's Signature												
Registr	au (	sep 1821	1 100	2 mil	500 F								

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1- State of Maryland / Department of Health and No.		g. No. 2 0 0	32163
r	Physicia	an	1. Decedent's Name (First, Middle, Last)	Date of Death     Month	Day Year	3. Time of Death
	/Medic	_	William O. Fox, Sr	Septembe		
à	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death		4c. County of Dea	th
			Pleasant View Nursing Home Mt. Airy  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Carroll 9. Bir	thplace (State or Foreign
	Funeral Dire <u>c</u> tor		215-16-1346  Usual Residence of Decedent  1 □ M 2 □ F 88 Yrs. Months Days Hours Min.	(Month, Day, ) Apr 30,	Year) C	MD
	rland ow	Ì	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	Mary I-f sh	tor	MD Carroll Mt. Airy			1 Maryes 2 No
	or 28s	Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What C	ountry?
	th wit		4101 Old National Pike 21771		USA	
Maryland 21215-0036	72 hours after death with the Maryland natural", or Items 23a or 28a-f show ilical Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  1 Never Married 2 Married  3 Nover Married 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Nover Nover Nover Married 2 Nover November Nover Nover Nover Nover November	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whi	
200	72 hor	Completed	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ring 1	6b. Kind of Business	/Industry
215	be filed within 72 ho ital Hygiene. do other than "natu event, the Medical	nple	Elementary/Secondary (0-12) College (1-4or 5+)			
2	il Hygier other th		10 Dairy Salesman	e (First, Middle, M	illow Far	ms Dairy
and		Be			,	
$\frac{2}{2}$	hould id Me mark matic	2	John D. Fox  Clara  19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Ru	R. Powel		Zin Code)
Ma	s 1 and 2 should f Health and Mer Item 27 Is marke other traumatic		Patricia Ann Feeser/daughter P.O. Box 416 Ocean Ci		21843	
ē,	s 1 ar f Hea ltem other		20a. Method of Disposition 20b. Place of Disposition (Name of		0c. Location - City or	Town, State
Baltimore,	Pages nent of I int: If Ite		1 ☑ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Meadow Branch Cemetery 9/2	25/2009	Westminst	er. MD
alti	artn artn Prit.		21. Signature of Funeral Service Licensee 22 Name and Address of Eacility HO			
m	permi Depa Impo any Is		412 Washington Ro	ad Westn	minster, M	
,	Physician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition  a. RISHT LOBAR PNEUM	st,	Approximate Interval Between Onset and Death	
¥	/Medical Examiner		Due to (or as "consequence of):			A4 10
7		<u>-</u>	b. Secuentially list conditions if any, leading to immediate b. Due to (or as a consequence of):	TILUKE		1-(02108)
	uted nsit	nin.	Cause (Disease or injury		Jean	
Ć	ificate be executed g physician and as the burial-transit	Examiner	resulting in death) Last Due to (or as a consequence of):	17 6-		
68760,	te be ysicia ie bur	edical	d. HIPERTENSION			Jean
	= 0 a		IF FEMALE.			
.O. Box	that the death certi red by the attending detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown  23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown		23d. Date of de Month	elivery Day Year
<u>ر</u>	res that igned b	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did toba	acco use contribute	to the cause of death?
ords	w require been sig should b	ed b	HYPERCHOLE STEROLEMIA	1 ☐ Yes	s 2□No 3₽F	Probably 4 □Unknown
Records,	The la ate has page 2	Completed	DEMENTIA	24a. Was an autopsy perform 1□ Yes 2	prior to	
Vital	Physician: Th r this certificate ral director, pag	Be (	eyaminer?	th (Check only one	)	
0	S S S	ဥ			nce 6 Other (Sp	ecify)
uC.	ding Ph h. After th funeral	ion	1 Volatural 5 Pending (Month, Day Year) Injury Work?	28d. Describe how	w injury occurred	
Division	e ta ce	icat	3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office	28f. Location (Stre	eet and Number or F	Rural Route Number.
<u>≤</u>	after Dire	Certification:	4 Homicide determined building, etc. (Specify)	City or Town,	State)	
	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by th	Medical C	29a. Certifier  (Check only one)  1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place and manner stated.			
	To the within 2 To the complet	Me	29b. Signature and title of pertifier 29c. License number		d. Date signed (Mor	
			N- L Delle D- 30469	5	prenter	23, 2009
1	5		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OC PARKWAY			
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 3 2009  32/Registrar's Signature  3. parks			

			1 - For State Registrar		e of M	arylan	d / Depa <i>Cei</i>	artmen rtificate	t of H	ealth a Death	and M		Reg. No.	109	32164
	Physici	an	Decedent's Name (First, Middle									2. Date of De Month 09-2		Year	M M
	/Medic	al	MARVIN FANN  4a. Fecility Name (If not institution		d number)			Ab City	Town or	Location of	of Death	09 2		unty of Dea	Z:11 A
	Examin	er	FUTURE CARE PIN	_	a number)				NTON	Location	or Boatin			-	GEORGE's
	Funeral		5. Social Security Number	6. Sex		je (In yrs.	last birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir (Month, Da	th	9. Bi	rthplace (State or Foreign
	Director		258-40-2684	1 <b>∑</b> M 2□	F	79	Yrs.	Months	Days	Hours	IVIII I.	09-22	-1929		CORGIA
	and *		Usual Residence of Decedent  10a, State 10b, County			10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Maryl f sho	tor	MD PRINCE	GEORGE	¹S		CLIN	TON							1 TYes 2 □ No
	r 28e	Director	10e. Street and Number					10f. Zip	Code				10g. Citizer	n of What C	Country?
	23e o		2669 PINEWOOD	DRIVE				2	0601				U.S.		
	tems	Funeral	11. Marital Status	Arme	Decedent d Forces?	,	.S. 13.	Was Deced	dent of Hi	spanic Ori n, Mexicar	gin? (Spe 1, Puerto l	cify Yes or No Rican, etc.)	)- 14.	Race - Am Black, Wh	encan Indian, ite, etc.
30	hours after death with the Maryland turel', or items 23e or 28e-f show al Exertimest be notified at	by F	1 ☐ Never Married 2 ☐ Mar 3 ☐ Widowed 4 ☐ Divorced	If Va	res 2 ☐ s, Give or Dates:	No		1 ☐ Yes	2 XN0	Specify:			Sp	pecify:	BLACK
215-0036	within 72 hours after death with the Marylar iene. rthen "neturel", or items 23e or 28e-f show then "mytical Examirm mat be mytified at	ted t	15. Deceder	it's Education			16a. Deced	dent's Usua	al Occupa	ation			16b. Kind of Business/Industry		
2	filed within 72 Hygiene. Ither then "ne int, the Medic	Completed	(Specify only higher Elementary/Secondary (0-12)		ite <i>d)</i> ige (1-4or	5+)	life. I	kind of wo	se retired,	)	t of workii	ng			ALLES AND AND AND
N	filed wi Hygien sther th	Con	12TH GRADE				PARKI	NG AT	TEND		d. Name	(F*****			OVERNMENT
yland	d d d d d	Be	17. Father's Name (First, Middle, MARVIN FANN, S									(First, Middle E SNEA		rname)	
	or by North	ပ္	19a. Informant's Name/Relations		·)		19b. Mailir	ng Address	(Street a	and Numbe	er or Rura	l Route Numb	er, City or T	own, State,	Zip Code)
Ma	d 2 7 is		DONNA JACKSON	- DAUGHT	TER		5305	MELWO	OD P	ARK A	VE,	UPPER :	MARLBO	ORO, M	ID 20772
e,	ite it		20a. Method of Disposition  1 Burial 2 Cremation	3 Demoval	from State	20b. P	Place of Dispo	sition (Nar natory or o	ne of ther place	9)	D	ate	20c. Loca	tion - City o	r Town, State
Ĕ	Pages ment of l		`4 Donation 5 Other (5		TOTT OTATE	FO	RT LIN	COLN	CEME	TERY	9-26	<b>-</b> 09	BLADEN	ISBURG	G, MD
Baitimore,	permit. Page Department of Importent: if any injury or once.		21. Signature of Funeral Service	Licensee			22	2. Name an	d Addres	s of Facilit	PIN	CKNEY- WASH,	SPANGI	ER F	H.
			23a. Part1. Enter the disease, o	omplications t	hat cause	d the deat								JUZ-32	Approximate
	Pnysician		Immediate Cause (Final disease or condition 2 PNEUMONTA 1WEEK											Interval Between Onset and Death	
	/Medical		resulting in death)		e to (or as		uence of):								I WP.P.K
	Examiner	L	Sequentially list conditions,	b											
	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	₹ Du	e to (or as	a conseq	uence of):								
	be executed ician and burial-transit	Examin	that initiated events resulting in death) Last	c	e to (or as	a conseq	uence of):								
760		ical		d											
9	death certificate e attending phys id for use as the	ed	IF FEMALE:	1											
ROX	ath ce ttendi or use	Physiclan/M	23b. Was decedent pregnant in the past 12 months?	101	s, outcome ive birth	2 Feta	ildeath 3□	Ectopic pr					230	d. Date of d	elivery Day Year
	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Pregnant a Jnknown	it time of d	eath 5L	Other (sp	есту) <sub>—</sub>		<del></del>				
<u>,</u>	res that t igned by be detar	by Ph	Part II. Other significant conditi	ons contributing	to death t	out not res	ulting in the u	nderlying c	ause give	en in Part I		23e. Did	tobacco use	contribute	to the cause of death?
cords	= 0 0		PARKINSON'S I	ISEASE								1 🗆	Yes 2□	No 3 □ f	Probably 4 XUnknown
ဝ၁	> 10 m	Completed	ATHEROSLEROTIO	CARDIO	VASCU	JLAR	DISEAS	E				24a. Was		24b. Were a	autopsy findings available completion of cause of
r	The ate h page	Сош											ormed? 2 TNo	death?	
VITA	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medica examiner?	Hospital:					Othe	ar.		(Check only			
0	Phys r this ral dii	To To	1 ☐ Yes 2 XNo 27. Manner of Death		1 lnpati		ER/Outpatier 28b. Time o		JA	4 1111		me 5 🗌 Res 28d. Describe			pecify)
0	Attending Is death.  ector: After by the funer	tlon	1 □Natural 5 □ Pendi	ng igation	Date of Inju (Month, Da	ıy Year)	Injury	М	28c. Injury Work 1 □ `	<br Yes 2□	No				
UIVISION	of or Attendiater death.  Director: A din by the fu	ertification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 200.	Place of In	jury - At h	ome, farm, str	reet, factor	y, office				(Street and I wn, State)	Number or I	Rural Route Number,
5	spitel or ours afte nerel Dir filled in I	0													
	Ho: Fur tely	edical				of examina									as stated. ue to the cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certific	-00	R	,		290	c. License	number			29d. Date	signed (Mo	nth. Day, Year)
			)	200		og		D	0505	45			09-2	21-09	
	10		30. Name and address of person						GOD	SWILI	.0.	OKOJI,	MD	-	
	Sta	ite	7513 NEW HAMPSH 31. Date filed (Month Park) Pear SEP 2 4 2009	Seneral	NUE, 32. Regist	TAKO.	MA PAR	K, MD	20	912_					
	Registr		254 % 4 5003	Lenous	0.	1414	Mar								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** eptember /Medical m 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner ROGIONAL 54/15bUL HICOMICO If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days 1 **X**M 2□ F 97 Maryland Director 212-01-2034 06/25/1912 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10b. County show ir than "natural", or items 23a or 28a-f show 1XYes 2 No Director Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 826 Springfield Circle death v by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status 1 and 2 should be filed within 72 hours after a Health and Mental Hygiene. em 27 is marked other than "natural". or itea 1 X Yes 2 □ No
If Yes, Give Army/
Year or Date: TCorp 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 XNo Specify. Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) office manager processing Equipment Co 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Ellwood B. Fields Clara Rachel Cox ပ or other traumatic 19a. Informant's Name/Relationship (Type. Print)
Fay T. Fields/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 826 Springfield Circle, Salisbury, MD 21804 permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any injury or other trau once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/22/09 Salisbury Crematory Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 1. Signature of Funeral Service Licensee 2. Name and Address of Facility Holloway Funeral Home Professional Association 4 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. CFSP Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DS disease or condition resulting in death) /Medical Examiner Sequentially list conditions Examiner cause. Enter Underlying Cause (Disease or injury that initiated events burial-transit law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the I as IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) signed by the a P.O. Tyes 2 TNo 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, þ 1 Yes 2 No 3 Probably Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was ar Jas autopsy page perform certificate l 2 □No 1 □ Yes 2 No 1 ☐ Yes Physiclan: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital; Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 1 ☐ Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending (Month, Day, Year) 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No after death 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death and place. To the Hospital 29a, Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title bracertifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Eastern 000 nive 31. Date filed (Month, Day, Year) 32. Pégistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

Maria Dietz Gaut	tsch	Please Type or Print in Black Indelibit  State of Maryland / Department			3 A E -
		1- For State Certificate		Reg. No.	2009 3216
Physicia	ın/	Decedent's Name (First, Middle,Last)		2. Date of Death  Month Day September 21, 20	3. Time of Death
Medical Exami	ner	Maria Dietz Gautschi 4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		County of Death
		11108 Luxmanor Road	Rockville		ntgomery
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday		8. Date of Birth (MM/DE	9. Birthplace (State or Foreigr CZECHOSLOVA)
Director		267-60-3685 1_M 2\[ \frac{1}{3} \] 81	Yrs. Months Days Hours Min	JUL 26, 19	028 Czechoslovakia
8		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits
ow any					1 Yes 2 X No
ryland ia-f sh	cto	MD Montgomery North Be	10f. Zip Code	10g. Citize	n of What Country?
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at one.	Director	11110 Luxmanor Road	20852	Unite	ed States
with with ms 23s			Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	Race - American Indian, Black,     White, etc.
r death or ite	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2 X No			
s after rral",	ā	or Dates:	Yes 2 X No specify: edent's Usual Occupation (Give kind of		pecify: Caucasian
2 hour	ted		ng most of working life. DO NOT use ret		a of Basinessi industry
5-0036 iled within 7 Hygiene. I other than	Completed	12 Hor	nemaker	Or	wn Home
5-0 iled w Hygie I other		17. Father's Name (First, Middle, Last)	18.Mother's Nam Marie	e (First, Middle, Maiden S	urname) NAVAILABLE)
2121 vuld be fi Mental I marked	o Be	Josef Dietz  19a. Informant's Name/Relationship (Type, Print ) 19b. Ma		•	·
MD 2 d 2 shou lth and N n 27 is n	1	Craig Gautschi / Son	eiling Address (Street and Number or D2 Highland Forest khaw, NC 28173	Drive	or rown, state, zip sode,
e, N I and I Health item item		20a. Method of Disposition 20b. Place of Dis	sposition (Name of cemetery, or other place)	Date 20c. Lo	ocation - City or Town, State
MOF Pages ent of nt: If		Dullai 2 / Cientation 3   Removal nom State		/24/2009 Gle	n Burnie, MD
Baltimore, permit. Pages I ar Department of Hee Important: If ite		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Thibadeau Mortuar	v Service.	P.A.
		M01508  23a. Part I. Enter the disease, or complications that caused the death. Do not en	933 Gist Ave., LL	. Silver Spi	ring, MD 20910
Physician /Medical		failure. List only one cause on each line.		or respiratory arrest, shock	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Hypertensive Atherosclerotic Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	ardiovascular Disease		
		Sequentially list conditions, b			
	iner	if any, leading to immediate cause. Enter Underlying Cause			
B = 15	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
e executed cian and rial - transit		d.			
30, te be e: ysiciai	ledic	UNPENDED   #MENTH, 9–24–09, BMW, Mo  IF FEMALE: 23c. If yes, outcome of pregnancy	<u>Co</u>	23d	Date of delivery
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Pumeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	cian/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 Live birth 2	Fetal death 3 Ectopic pregn		Month Day Year
OX 6	. <u></u>	1 Yes 2 No 9 Unknown 9 Unknown	Other (Specify)		
O. B nat the de ed by the etached	Phy	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobacco us	se contribute to the cause of death?
5, P.O. irres that the signed by the detached	db	Diabetes Mellitus		1 Yes 2	No 3 Probably 4 V Unknown
Division of Vital Records, tall or Attending Physician: The law requir stafer death.  al Director: After this certificate has been steen in the fine by the fineral director, page 2 should	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
Vital Records hysician: The law requi	d mo			performed? 1 ✓ Yes 2 No	death?
Vital Rec ysician: The I his certificate I director, page	စ	25. Was case referred to medical	26.Place of Death (Check	conly one)	
Vita hysici this c	10 B	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpa			ce 6 Other: Scene
n of ding Ph		(Month, Day, Year)	e of Injury 28c. Injury at Work?	28d. Describe how injur	y occurred
Sior Attend r death ector: by the	cati	2 Accident Investigation 28e Place of Injury - At home farm		28f. Location (Street an	d Number or Rural Route Number, City
Divi	Certification:	3 Suicide 6 Could not be determined (Specify)	Stroot, ractory, omeo banding, etc.	or Town, State)	2
Hospi 24 hou Funer tely fil		29a. Certifying Physician: To the best of my knowledge, death of (Check only)	occurred at the time, date and place, an	d due to the cause(s) and	manner as stated.
Division  To the Hospital or Attent within 24 hours after death. To the Funeral Director: Completely filled in by the	Medical	one) 2 Medical Examiner: On the basis of examination and/or investant and manner stated.	stigation, in my opinion, death occurred	at the time, date and place	e, and due to the cause(s)
F 3 F 3	ĭ	29b. Signature and title of certifier	29c. License number		ate signed (Month, Day, Year)
12		When Brane 4 MM	O.C.M.E.	Sept	ember 22, 2009
		30. Name and address of person who completed cause of death (Item 23a)  Melissa Brassell, MD Assistant Medical Examiner 11	11 Penn Street, Baltimore, MD	D 21201	
2	ate				
Regist		31. Date file (Host), Day, Year 2009 Service 5. Again 1989.	while the same of		

ORIGINAL

1 - State Registrar

**Funeral Director** 

Be Completed by

ဂ္

Examiner

Physician/Medical

þ

Be Completed

Medical Certification; To

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3 2009

600

32. Registrar's Signature

**Physician** 

/Medical

Examiner

**Funeral** 

**Director** 

Physician

Registrar		,	•		of Death		lental Hygid Red	, No. 2	19 3216
Decedent's Name (First, Middle, La	st)						2. Date of Death		3. Time of Death
Romaine Th	eresa	Gray					Sept 20,	2009 Y	05:15 M
Facility Name (If not institution, giv		,			wn, or Location			4c. County of	
Washington Adve		OSPITAL 7. Age (In yrs. last I	hirthday	If Under 1	akoma P	ark r 24 Hrs.	8. Date of Birth	Montg	omery  D. Birthplace (State or Foreign
	M 2XIF	7. Age (III yrs. last I	Yrs.		Days Hours	Min.	July 29	rear)	Country) Maryland
ual Residence of Decedent									1,000
. State 10b. County		10c. City, To							10d. Inside City Limits
MD P.G	•	C.	lint	ON 10f. Zip O	ode .		10	g. Citizen of Wh	1 Yes 2 No
7311 Roselynn	Court			101. Zip O	20735		10		States
Marital Status	12. Was Dece	dent Ever in U.S.	13.	Was Deceder		rigin? (Sp	ecify Yes or No- Rican, etc.)	14. Race -	American Indian,
1 ☐ Never Married 2 ☐ Married	Armed For	2 <b>)</b> (No		_			Rican, etc.)		White, etc.
3 Widowed 4 □ Divorced	If Yes, Giv Year or Da			1∐Yes 2⊡	X Specify	·.			Black
15. Decedent's Ed (Specify only highest gra	ducation ade completed)	16	Sa. Dece (Give	dent's Usual ( kind of work	Occupation done during mo retired)	st of work	ing	6b. Kind of Busi	
Elementary/Secondary (0-12)	College (1	-4or 5+)		elath	Aide				Service ealth Human
Father's Name (First, Middle, Last) Elize Newman	)						e (First, Middle, Ma .e Butler	aiden Surname)	
a. Informant's Name/Relationship (							al Route Number,		tate, Zip Code)
a. Method of Disposition	Daugne			sition (Name					ity or Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		00000	tery, cřei	natory or othe	er place)	v 9/2			, Maryland
. Signature of Funeral Service kice		11004							nc 6633 01d
Amis Diffe	d n	00257					ad, Clin		
a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that ca	aused the death. D							Approximate Interval Between
mediate Cause (Final	Ar III	te cer	espi	1900	culor	a	cciden	X	Onset and Death
sulting in death)	a. Due to (	or as a consequenc	e of):	0.00	0.001		- 000000	- 0	
quentially list conditions	b BY	east		ance	4				
ny leading to immediate	b. By	or as a consequenc	ce of):	anco	4_				
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equentially list conditions, any, leading to immediate use. Enter Underlying use (Oisease or injury at initiated events sulting in death) Last  FEMALE: b. Was decedent pregnant in the past 12 months?  1	c	or as a consequence come of pregnancy pirth 2 □ Fetal dealeant at time of death	ce of):	Ectopic pre				23d. Date Mont	
Inty, leading to immediate use. Enter Underlying use (Disease or injury at initiated events sulting in death) Last  FEMALE: b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No	C	or as a consequence come of pregnancy irth 2 ☐ Fetal deceand at time of death	ee of): ath 3[	Other (spec	cify)	l.	23e, Did toba	Mont	
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ny, leading to immediate use. Enter Underlying use (Disease or injury t initiated events ulting in death) Last  FEMALE: b. Was decedent pregnant in the past 1 aronths? 1 □ Yes 2 □ No 9 □ Unknown  t II. Other significant conditions of	CDue to (	or as a consequence come of pregnancy irth 2 ☐ Fetal deceand at time of death	ee of): ath 3[	Other (spec	se given in Part		1 ☐ Yes 24a. Was an autopsy perform	Mont acco use contrib c 2 \( \text{No} \) 3  24b. We price to the contribution of the	nute to the cause of death?  Probably 4 Unknown  are autopsy findings available or to completion of cause of ath?
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29d. Date signed (Month, Day, Year)

akoma parkin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, is certificate has been s director, page 2 should it

> State Registrar

# Baltimore, Maryland 21215-0036

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			State of Maryland / Departr	nent of Health and K icate of Death		0000 0100
	_	-	Registrar  1. Decedent's Name (First, Middle, Last)		Reg.	3. Time of Death
	Physici		JOHN H. GEOGHAN SR		Month _	18 - 2009 556 P M
7	/Medio			City, Town, or Location of Death	,	4c. County of Death
1	Examin	101	3660 JESTERVIlle RD	BIVALVE		Wicomico
	Funeral		Mc Mg (m) / Market Silver Mg	Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		VI 9_ VO 00 VO		1-4-193	52 MD
	aryland show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location	on		10d. Inside City Limits
	Mary a-f sh fied	tor	MD WICOMICO BIVAL	.VE		1 □Yes 2 🗷 No
	h the or 28a e noti	Director		0f. Zip Code	10g.	Citizen of What Country?
	flied within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the "sedeal Examiner must be notified at		3660 SESTERVILLE RD	21814		USA
	r dea	Funeral		Decedent of Hispanic Origin? (Sps., specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
36	s afte	by F	1 Never Married 2 Married 1 Yes 2 No 1 No	res 2. ☑No Specify:		Specify: WHITE
21215-0036	tural	ed t	15 Decedent's Education 16a Decedent'	s Usual Occupation	16b	b. Kind of Business/Industry
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Baltimore,	Pages nent of I ant: If ite		1 Li Buriai 2 Le Cremation 3 Li Removal from State	i -	-00 50	ALISBURY, MD
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			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter th shock, or heart failure. List only one cause on each line.	e mode of dying, such as cardiac	or respiratory arrest,	Interval Between
-	Physician		Immediate Cause (Final disease or condition A/7/QIMMY S	DICEASE		Onset and Death
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Ф.	that t ned by detad		Part II. Other significant conditions contributing to death but not resulting in the under	lying cause given in Part I.	23e. Did tobac	co use contribute to the cause of death?
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Ä	sician: The law certificate has b irector, page 2 s	mo			autopsy performed	prior to completion of cause of death?
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∑ V	Physic this co		1 ☐ Yes No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3			e 6 Other (Specify)
n o	ding P I. After 1 funera	ion:	27. Manner of Death  28a. Date of Injury  28b. Time of Injury  28b. Time of Injury	28c. Injury at Work?	28d. Describe how i	injury occurred
Division	I or Attendi after death. Director: /	icat	2 DACCIDENT	M 1 Yes 2 No	28f Location /Stree	et and Number or Rural Route Number,
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	ospita hours ineral iy filler		29a. Certifier Certifying Physician: To the best of my knowledge, death oc	curred at the time, date and place	, and due to the caus	se(s) and manner as stated.
	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	(Check only one) Medical Examiner: On the basis of examination and/or invest and manner stated.	gation, in my opinion, death occu		
	70 Vith	2	29b. Signature and title of cortifier	29c. License number	29d.	Date signed (Month, Day, Year)
	1000		the contract of the	1006017	٥	
	1-8M		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	BOX 1733 S	obel.	MD 2/802
	Sta	ite	31. Date filed (Month, Day, Year)  32. Degistrar's Signature	0,110)	)	The Oliver
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Physician
/Medical
Examiner

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examinar is ust be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

	Registrar			Cert	tificate of l	Jeath			Reg. N	lo,	113	0 4 1 0	)	
	1. Decedent's Name (First, Middle, L	ast)						2. Date of D	Death			3. Time of Deat	th	
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	William David H	iart, Jr.						SEPTE	TREK	44,	2009	6:57 a	a'"	
r	4a. Facility Name (If not institution, g	give street and number	)		4b. City, Town, or	Location	of Death		4	c. County	of Death			
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						_	_			TOTICE				
	Social Security Number     6.		ge (in yrs. last i	**	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of E (Month,	Birth D <i>av. Y</i> ea	r)	9. Birth	place (State or For ntry)	reign	
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	Usual Residence of Decedent								, -					
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D D	4E Decedents	Education	14	Sa Docada	ant's Heuri Occur	ation			16h	Kind of R				
15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business (Specify only highest grade completed) (Give kind of work done during most of working								usiness/ii	icustry					
₫	Elementary/Secondary (0-12)	College (1-4or	5+)	life. Do	O NOT use retired	)		-						
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3		-41						/Fin-4 2 4						
Be Completed by Funeral Director	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Surname)									,				
William David Hart, Sr. Jessie Nic									hols					
-			F											
	19a. Informant's Name/Relationship	(Type. Print)	1	9b. Mailing	Address (Street a	and Numb	er or Rura	u Route Nun	nber, City	or Town	, State, Zi	p Code)		
	Loretta B. Hart	- / Wife		7710	Maple Av	<i>#</i> 1	007	Takom	a Pa	rk	MD 20	910		
	20a. Method of Disposition	- / MTTC						ate				own, State		
	1 ☐ Burial 2 X Cremation 3	Removal from Ct-4-	ceme	tery, crema	tion (Name of atory or other plac									
	1 ☐ Burial 2 ▲ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of the Contro				Cremator		09/26	/2009	Gle	en Bu	ırnie	, Marylan	nd	
21. Signature of Funeral Service Licentee 22. Name and Address of Facility Thibadeau Mortuary Service, P.A.														
	mu d / /	Wer 1	100956	q	33 Gist	A376	T.T.	Silva	r St	ring	, MD	20910		
_										71 1112	,, 111			
	23a. Part1/Enter the disease, or co	mplications that cause ly one cause on each l	d the death. D	o not enter	r the mode of dyin	g, such as	cardiac c	or respiratory	arrest,			Approximate Interval Between	n	
23a. Part1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaft failure. List only one cause on each line.  Immediate Cause (Final												Onset and Death		
disease or condition SEPSIS												DAYS		
resulting in death)  Due to (or as a consequence of):														
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Ĭ	IF FEMALE:													
<u> </u>	23b. Was decedent pregnant	23c. If yes, outcome		oth o	Ectopic pregnancy	,				23d. Da	ate of deliv	ery		
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Completed by Physician/Medical Examiner	Part II. Other significant conditions	contributing to death I	out not resulting	g in the und	derlying cause give	n in Part I	l.	23e. Di	tobacce	use con	tribute to	the cause of death	1?	
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บั								24a. Wa	e an	24h	Were aut	opsy findings avail	ahla	
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5	1 XNatural 5 ☐ Pending	28a. Date of Inj (Month, D	ay, Year)	Injury	Work	?	į	_54. D05011D	- 11011 111	, occur				
6	2 ☐ Accident investigat				M 1 🗆	Yes 2□	INo							
ا ڍ	3 ☐ Suicide 6 ☐ Could not	be 28e, Place of In	iury - At home	farm. stree	et, factory, office		1	28f. Location	(Street	and Num	ber or Rui	ral Route Number,		
3	4 ☐ Homicide determine	28e. Place of In building, e	tc. (Specify)	, 5000	, 2.,, 300		1.		own, Sta					
Medical Certification: 10														
	29a. Certifier 1 X Certifying	Physician: To the bes	of my knowled	ige, death	occurred at the tir	ne, date a	nd place	and due to t	ne cause	(s) and m	nanner as	stated.		
ا دّ	(Check only 2 Medical Ex	aminer: On the basis	of examination											
ığ	one)	and manner s												
Ĭ	29b. Signature and title of certifier				29c. Licens	number			29d. [	Date signe	ed (Month	Day, Year)		
		///												
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1		11/1	<b>-</b>			007			וחנו		2	2, 2007		
	30. Name and address of person wh	·	•	, , , , .	•									
	IRA RABIN, M.D.,	1500 FORE	ST GLE	N ROA	D, SILVE	R SPR	RING.	MD 20	910					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 **Physician** 19, Sept 1:44 A M Stewart E. Helmer /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 10, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 ★ M 2 □ F Ĩ'939 Michigan 380 38 2984 69 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination must be rediffed at 1 ☐ Yes 2 ☐ No Directo Maryland Prince George's Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9711 Green Apple Turn 20772 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No Korean If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 No Specify þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Gov't House Photographer <u>Photography</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clarkson C. Helmer Helen F. Smith ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia Helmer (Wife) 9711 Green Apple Turn, Upper Marlboro, MD 20772 20c. Location - City or Town, State 20a. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 9-25-2009 Suitland, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee Alexandria Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATherose CARTIOVACO **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami execu burial-trar Due to (or as a consequence of): Box 68760, physician The law requires that the death certificate be Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. 1 Tes 2 No the detached 9 Unknown 9 Unknown ss been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ thknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 s performed 2 🗆 No 1 ☐ Yes 1 🗌 Yes ttending Physician: Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) After this of funeral dire 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 1 Inpatient 27. Manne Death 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 atural (Month, Day, Year) 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident afte deal filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide the Hospital or within 24 hours a 29a. Certifier certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar DHMH 17 Rev 1/2001 29b. Signature and title of certifier

person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29d. Date signed (Month, Day, Year)

09-07241 Cedric Holmes Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ 1859 hrs September 15, 2009 Med al Examine CEDRIC HOLMES 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death  $\vec{D}$ Prince George's Prince George's Hospital Center Cheverly If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number Funeral Months Davs Hours Country) Director 01/29/1979 VA 1 X M 2 F 30 225-19-2169 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County ž Yes 2 X No s 23a or 28a-f show : Bowie Prince Georges Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 20715 USA 15520 Orchard Run Drive 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Itimore, MD 21215-0036
it. Pages I and 2 should be filed within 72 hours after death wit rument of Health and Mental Hygiene.
ortent; I (tien 27 is marked other than "natural", or items 2 yr o other traumatic event, the Medical Examiner must be a White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married Married 2 X No Yes Specify: Black Yes 2 X No specify: Widowed Divorced If Yes, Give Year ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Private Construction Worker 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clifton Nathaniel Holmes, Sr. Louise Simpson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) 15520 Orchard Run Drive Bowie, Md. 20715 Louise Holmes - Mother 2Cc. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9-23-2009 Rockville, Md. Parklawn Cemetery Donation 5 Other Specify 21. Signature of Euperal Service Licensee 22. Name and Address of Facility Marshall's Funeral Home of Maryland 4308 Suitland Rd. Suitland, Md. 20746 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last requires that the death certificate be executed Physician/Medical UNPENDED AMENDED attending physician or use as the burial O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy Year 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) Yes 2 No 9 Unknown 9 Unknown tached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed be be deta Yes 2 ✔ No 3 Probably 4 Unknown ģ Records, P. Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has b rector, page 2 sh The law performed? death? 1 🗸 Yes No ✓ Yes 2 No 26.Place of Death (Check only one) e Hospital or Attending Physician; 24 hours after death. 25. Was case referred to medica Division of Vital Be examiner? Hospital: 1 Other<sub>4</sub> Nursing Home 5 Residence 6 Other: Inpatient 2 V ER/Outpatient 3 DOA this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? After 1 28b. Time of Injury 27. Manner of Death Certification: Subject shot Sep 15, 2009 1754 hrs within 24 hours after ucare.

To the Funeral Director: A Natural Yes 2 V No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State)
Eastern Ave. NE/1700 Blk. Olive Street , Capitol Heights determined (Specify) Lpcal Street 4 V Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier September 16, 2009 O.C.M.E. lame and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Laron Locke MD. Assistant Medical Examiner 31. Date filed (Month, Day Yes 32. Registrer's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death September 21, 2009 **Physician** Lawrence Isaac Jacobson 5:25 P M /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kensington Nursing & Rehab. Center Montgomery Kensington If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours Min. 04/08/1925 PA<sup>Country)</sup> 11∆ M 2□ F 84 193-16-8073 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Maxical Examinant must be retilled at 1X Yes 2 □ No Director MD Montgomery Silver Spring 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1121 University Boulevard West, #1118 20902 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 194 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐Yes 2 ☐ No 1948 — If Yes, Give Year or Dates: 1951 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White <u>S</u> 1∐Yes 2XINo 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Pharmacy 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Jacobson Eleanor Pech ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Jo Ramboz-Daughter 10786 Forest Edge Circle New Market, MD 21774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Lebanon Cemetery 09/23/2009 Adelphi, Maryland 22. Name and Address of Facility Edward Sage1 Funeral Direction, Inc. 1091 Rockville, MD 20852 21. Signature of Funeral Service Licensee MO1255 Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Disease **Physician** ) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) certificate be executed and burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE ISe 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 100 Division of Vital Records, P.O. the 9 Hlnknown ģ signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an page 2 s has autopsy certificate 1 □ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After this funeral d To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 17 Rev 1/2001

State Registrar

29b. Signature and title of certifier

Summer 31. Date filed (Month, Day, Year) Gaithesburg

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SANDEEP

3. Registrar's Signature

Walk

29c. License number D0064624 29d. Date signed (Month, Day, Year)

(eptenber 22, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month Day 20 **Physician** 2009 Molita Margaret Jones September 7:55p /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Carrol1 Transitions Health Center Sykesville If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 ☐ M 2 👿 F 124-22-4194 84 Director Feb 16 1925 Canada Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, The Medical Examinar must be presented once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Carrol1 MD Sykesville 1 ☐ Yes 2 ☐ No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7150 Harlan Lane 21784 Canada 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∏Yes 2 1 No If Yes, Give A Year or Dates: 1 Never Married 2 Married Completed by 1 □Yes 2**X**□No Specify: Specify: White 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) health care medical receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Roe Andrew McLellan ٥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr. Steven Jones 7150 Harlan Ln., Sykesville, MD 21784 (son) 20a. Method of Disposition
1 □ Burial 2 ὧ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State All County Cremation 9-21-09 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee Dauge Haigert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☑ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Yes 22No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Jursing Home 5 Residence 6 Other (Specify) Hospital: 2 1 1 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ۵ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1. Natural 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 □Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

MANNUGO

31. Date filed (Month, Day, Year) SEP 2 2 2009

29b. Signature and tile of certifie

₹32. Registrar's Signature

Registrar

29d. Date signed (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Monto 9/19709 16:20 Willie J. Jones 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Washington Adventist Hospital Montgomery Takoma Park 8. Date of Birth (Month, Day, Year) 03/08/1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Days Hours 1 2 M 2 ☐ F Months 239-34-5478 80 South Carolina Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 □ No DC Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2344 14th Street NE 20018 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2K No **Black** Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meat Receiver Private 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Jones Mattie Wilson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Dwight H. Jones/ Son 823 Glen Allen Drive Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 XBurial 2 Cremation 3 Removal from State Ft. Lincoln 4 Donation 5 Dother (Specify) 26. 2009 Brentwood, Maryland 22. Name and Address of Facility dung of Function Service Licenta Stewart Funeral Home, Inc. 20019 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Menina Due to (or as a conse (u) nce of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or a a consequence If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 🗌 Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred

**Physician** /Medical **Examiner** 

Physician

/Medical

Examiner

**Funeral** 

Director

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Director

Funeral

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination must be notified at once.

Baltimore, Maryland 21215-0036

and burial-trar led by the attending physician detached for use as the buria cate has been signed by page 2 should be detach certificate

The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Physician/Medical ð Completed Hospital or Attending Physician; 1 24 hours after death. Funeral Director: After this certifica Be

completely filled in by the funeral director. Certification: To

Medical within 2 Registrar

State

n 24 hours a

23b. Was decedent pregnant in the past 12 months? ☐Yes 2☐No 9 Unknown

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

28c. Injury at Work?

1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title

29d. Date signed (Month, Day, Year)

of death (Item 23a) (Type, Print) Name and

31 Date filed (Month, Da 24

5 Pending investigation

6 ☐ Could not be

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 09=25-2009 0428 A **Physician** Wayne Preston Keen /Medical 4c. County of Death Harford 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Havre de Grace 306 Robinhood Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-28-1922 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday Days Maryland 1**∑**M 2□F 86 216-18-5937 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Director Havre de Grace Harkord Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States of America 21078 306 Robinhood Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 MYes 2 □ No If Yes, Give Year or Dates: WW 1 1 White 1 ☐ Yes 2 No Specify. 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Seakood Commercial Waterman 18. Mother's Name (First, Middle, Maiden Surname) Lillian Mae Preston 17. Father's Name (First, Middle, Last) Be Henry Maxwell Keen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin Code) 618 Water St. Havre de Grace, Mary Land 21078 19a. Informant's Name/Relationship (Type. Print) (daughter) Vicki Ferguson 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Harford Memorial Gdns 09-30-2009 Aberdeen, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Zellman Funeral Home, P.A. 123 S. Washington St. Havre de Grace, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each light. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 □ Yes 2 **X** No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, After this certificate has been signed by the funeral director, page 2 should be detached within 24 hours after death.

To the Funeral Director: A

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination until the neutified 3 once.

Physician /Medical

Examiner

and burial-trar

attending physician for use as the burial

3altimore, Maryland 21215-0036

State Registrar

filled in by the

(Check only one)

29b. Signature and title of certifier

DHMH 17 Rev 1/2001

441

DK

29c. License number

29d. Date signed (Month, Day, Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a)

**ORIGINAL** 

	,	State Registrar	of Maryland	/ Depa		Health	and M	ental Hyg	jiene eg. No. 🤈		32176	
Dhysia	ian	1. Decedent's Name (First, Middle, Last)						Date of Deat     Month		Year	3. Time of Death	
Physic /Medi		Elizabeth Patton Le						09	19	2009	1:00P M	
Exami	ner	4a. Facility Name (If not institution, give street and			4b. City, Town,					unty of Death	217	
		Washington ADventist  5. Social Security Number  6. Sex	7. Age (In yrs. las	t birthdav)	If Under 1 Year	a Park		8. Date of Birth (Month, Day		ontgome 9. Birthp	lace (State or Foreign	
Funeral Director		370-24-4107 1□ M 2 🗷 Usual Residence of Decedent		Yrs.	Months Day	s Hours	Min.	2/23/19	921	Geor		
yland how		10a. State 10b. County	10c. City,	Town or Lo	cation					1	Od. Inside City Limits	
he Mai 28a-f s	Director	DC None	Was	hingt	on 10f. Zip Code			1	On Citizon	of What Cour	1 X Yes 2 □ No	
with th		10e. Street and Number 6740 13th Place, NW			2001					ed Stat		
ns 23	Funeral	11 Marital Status 12. Was D	Decedent Ever in U.S.	13. V	Vas Decedent of f Yes, specify Cu		rigin? (Spe	cify Yes or No-	14.	Race - Americ	can Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Evaluation must be notified at any injury or other traumatic event, the Madical Evaluation.	by Fur	1 Never Married 2 Married 1 Yes.	I Forces? es 2፟፟X No Give or Dates:		fYes, specify Cu I∐Yes 2.2∰N			Rican, etc.)		Black, White, etc.  Specify: Black		
2 hou		15. Decedent's Education	- 1	16a. Deced	dent's Usual Occ kind of work don	upation	et of warkin	2	16b. Kind	of Business/Inc	dustry	
ithin 7	Completed	(Specify only highest grade complete Elementary/Secondary (0-12)  College	e (1-4or 5+)	`life. L	DO NOT use reti	red)	SI OI WOIKII	ng	DC C	overnme	n t	
illed w Hygie ther t		17. Father's Name (First, Middle, Last)	T   S	ocial	L Worker		er's Name	(First, Middle, i			:116	
Id be i lental rked o	To Be	John Bonner Patton				Mat	el F	reeman		ŕ		
VICELY VI		19a. Informant's Name/Relationship (Type. Print) Renager Lee, Jr./Husba			ng Address (Stre						_	
t Health	-	20a. Method of Disposition			13th P1 sition (Name of natory or other p					C 2001 ion - City or To		
Pages ment of lant. If ite		1⊠ Burial 2 ☐ Cremation 3 ☐ Removal fr 4 ☐ Donation 5 ☐ Other (Specify)	om State		Harmony		9/25	/2009	Lando	ver, MI	)	
permit. Departr Imports any inju		21. Signature of Funeral Service Licenses	111897)		Name and Add						ce, Inc. OC 20012	
		23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause	at caused the death.								Approximate Interval Between	
Physician	ı	Immediate Cause (Final disease or condition	CUTE	MY	OCAN	DAZ	Ī	NPY	aci	EN	Onset and Death	
/Medical Examiner	ı	resulting in death)	to (or as a consequer	of):	MYCA /A	211		NRA.	~	11		
P +	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	to (or as a consequer	nce of):	1110101	1,001		1000	- 31		-	
xecute and I-transi	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last	to (or as a conseque	nce of):	ENAT	1	122	ris ca	3			
te be executed ysician and le burial-transit	cal E	L <sub>d.</sub> Ž	TABE	76	> M	eri	Live	5				
rtificat ng phy		IF FEMALE:			-			,				
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	sician/Med	23b. Was decedent prognant in the past 12 months?	outcome of pregnand ive birth 2  Fetal d regnant at time of dea Inknown	eath 3	Ectopic pregna Other (specify)				23d	I. Date of deliv Month	ery Day Year	
that the dended by the detached	Phy	9 ☐ Unknown  Part II. Other significant conditions contributing t		ng in the ur	nderlying cause	given in Part	l.	23e. Did to	bacco use	contribute to t	he cause of death?	
w requires the speed signer is should be d	ted by							1.27	es 2 🗆 N	No 3□ Pro	bably 4 🗌 Unknown	
The law r te has be age 2 sh	Completed							24a. Was a autop: perfor	sv 🎤	24b. Were auto prior to co death? 1 □Yes	opsy findings available impletion of cause of	
ian: artifica ctor, p	Be C	25. Was case referred to medical examiner?				26. Plac	e of Death	1 □ Yes (Check only or		1 🗆 162	2 LINO	
hysic this co	2	1 Yes 2 No Hospital: 1	Inpatient 2 EF		IL 3 LI DOA			me 5 ☐ Resid			fy)	
ding F	ion:	1 ■ Pending (I	ate of Injury Month, Day, Year)	8b. Time of Injury	l W	ijury at /ork? □Yes 2□		28d. Describe h	ow injury o	ccurred		
Attener deat ector:	Certification:	3 Suicide 6 Could not be	ace of Injury - At hom uilding, etc. (Specify)	e, farm, str				28f. Location (S City or Tow		lumber or Run	al Route Number,	
oital or urs afte rral Dir												
To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical	29a. Certifier 1. Certifying Physician: To (Check only one) Medical Examiner: On the and results of the control of the control one)	the best of my knowled the basis of examination the basis of examination	edge, deat n and/or in	h occurred at the vestigation, in m	y opinion, de	and place, eath occurr	ed at the time,	date and pla	ace, and due t	o the cause(s)	
To ti To ti com	Ž	29b. Signature and title of certifier	M.	>	29c. Lice	ense number			29d. Date s	igned (Month,	Day, Year)	
		30. Name and address of person who completed of	cause of death (Item 2	3a) (Type	Print)	COM	(1)	7000	71	A In	10-	
		DAUDS NO	KONNE	المرو	/_	AN	OM	+ DA	ru.	MD	DESIL	
	ate	31. Date filed (Month, Day, Year)	Z. Registrar's Signatur	for	Ked				7	, ~		
Regist	rar	SEP 24 ZUUY KA	the man	(7								

			1 - For State Registrar	State of Marylan	•	rtment of F tificate of I			ene g. No. 2	30177	
	Physic	ian	1. Decedent's Name (First, Middle, Last)	Loo	CD.			2. Date of Death Month	r 27 2009	3. Time of Death	
	/Medi Exami	cal	Warren Kermit  4a. Facility Name (If not institution, give s	Lee	SR.	4b. City, Town, or	r Location of Death	Septembe	4c. County of Death	8:45 A M	
-	<i>}</i>		24215 Red Rock La			Rawlin	ıgs		Allegany		
	Funeral Director		5. Social Security Number 6. Sex 218–38–0551	7. Age ( <i>In yr</i> s. <i>I</i>	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) March 14	Year) 9. Birth Coul Mary	place (State or Foreign offry) Land	
	yland Jow		10a. State 10b. County	10c. City	y, Town or Lo	cation			1	0d. Inside City Limits	
	ne Mar 18a∽fsl	ector	MD Allegany	Rav	vlings					1 ☐ Yes 2, ☐ No	
	with th	al Dir	10e. Street and Number 24215 Red Rock La	ine		10f. Zip Code 21 55	57	,	. Citizen of What Country? Cited States		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exertine must be notified at once.	t by Funeral Director	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S Armed Forces? 1		Vas Decedent of H f Yes, specify Cuba □ Yes 2 No	lispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White, Specify: Whi	etc.	
15-(	n 72 ho "natu edicel	oletec	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occup	ation during most of worki d)	ng	6b. Kind of Business/In		
212	d withii giene. er than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		reman		E	Paper Manuf	acturer	
and	I be file intal Hy ed oth	Be	17. Father's Name (First, Middle, Last)  Elmer R. Lee	SR			18. Mother's Name	(First, Middle, Ma		'	
Maryland	nd 2 should lith and Me 27 is mark r traumatio	2	19a. Informant's Name/Relationship (Type Carol Lee/ wife				and Number or Rura	al Route Number, (	City or Town, State, Zip Maryland		
Baltimore,	Pages 1 ar nent of Hea int: If item iry or othe		20a. Method of Disposition  1XP8urial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)			sition (Name of natory or other place em. Garde		30/ Ke	oc. Location - City or To eyser, West		
Balti	permit. Departr Importa any Inju		21. Signature of Funeral Service Licenses	Bol		. Name and Addres	ss of Facility Boa	l Funera	l Home , Maryland	21562	
			23a. Part 1. Enter the disease or complice shock, or heart failure. List only one	ations that caused the death cause on each line	n. Do not ente	er the mode of dyin	ng, such as cardiac	or respiratory arres	et,	Approximate Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Gue to (or as a consequ		cer m	etastasis			2 years	
	Examiner	<u></u>	Sequentially list conditions, b.								
	cuted id ansit	Examiner	Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events c.	Due to (or as a conse.	ience ori;						
60,	tificate be executed ig physician and as the burial-transit		resulting in death) Last	Due to (or as a consequ	ience of):						
68760,	ificate I g physia is the b	edical	d.								
P.O. Box	Physician: The law requires that the death cert this certificate has been signed by the attending rail director, page 2 should be detached for use a	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal 4 ☐ Pregnant at time of do 9 ☐ Unknown	death 3	Ectopic pregnancy Other (specify)	у		23d. Date of deliv Month	ery Day Year	
Division of Vital Records, P.	uires that n signed b ild be deta		Part II. Other significant conditions cont		-	derlying cause give	en in Part I.		cco use contribute to t	he cause of death?	
eco	e law requir has been si je 2 should b	Completed by						24a. Was an	24b. Were auto	opsy findings available impletion of cause of	
a B	sician: The l certificate ha							autopsy performe 1 □ Yes 2	ed/ death?	n n	
Vit	ysiciar iis certif directo	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	spital: 1   Inpatient 2	ER/Outnatien	t 3 🗆 DOA Othe	26. Place of Death		ce 6 ☐ Other (Speci	6.1	
n of	ffe	Certification: To	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury Work	y at	28d. Describe how			
isio	Attendideath.	ficati	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	me. farm. stre		Yes 2□No	28f. Location (Stre	et and Number or Rum	al Route Number.	
5	Hospital or Attending 24 hours after death. Funeral Director: After rtely filled in by the funer	Certi	4 Homicide determined	building, etc. (Specify	()			City or Town,			
	To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier 1 ★ Certifying Physic (Check only one) 2 ★ Medical Examin	cian: To the best of my knower: On the basis of examinat and manner stated.	wledge, death tion and/or inv	occurred at the tir estigation, in my o	me, date and place, pinion, death occurr	and due to the cau red at the time, dat	use(s) and manner as e and place, and due t	stated. o the cause(s)	
	To the within 2 To the comple	Σ	29b. Signature and title of certifier			29c. Licenso			d. Date signed (Month,		
		10	30. Name and address of person who con	unleted cause of death (Itom	23a) (Tune 1		9031	5	eptember 28	2000)	
		JU	Dr. Donald Manger,	11600 Bedfor	d Rd.,	Cumberl	and, MD	215023			
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 8 200	32. Registrar's Signat	ure	ardas					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Day Year **Physician** Douglas Lee Laatsch 9:15 18 /Medical Sept 2009 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Hospice Dove House Westminster Carrol] 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Feb 10 1950 Birthplace (State or Foreign Country) **Funeral** Months Davs Hours 15₹M 2□ F 59 Director 217-54-9124 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is merked other than "natural", or items 23a or 28a-f show other treumetic event, the Maxical Experiment rust be rutified at Director 1 ☐ Yes 2 ☑ No Carroll Westminster 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21157 USA 800 Velvet Run Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ XNo Specify. چ Specify: 3 Widowed 4 Divorced White Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired)

Conference Elementary/Secondary (0-12) College (1-4or 5+) Asst.Director Event & Services Towson University 4 and 2 should be fil.
It of Health and Mental Hy.
If Item 27 Is merical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ruth Ann Shanklin Philip Laatsch ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Katherine Laatsch/wife 800 Velvet Run Drive Westminster, MD 21157 permit. Pages 1 a
Department of He
Important: If Item
eny Injury or othe 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation, Inc 9/24/2009 Hampstead, MD Signature of Funeral Service Licensee Pritts Tunerally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician /Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed ettending physician and for use es the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Vear Pregnant at time of death 5 Other (specify) signed by the e ☐Yes 2 ☐No Ö 9 Unknown g 🗌 Unknown <u>ت</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has page 2 autopsy performe death? certificate 2 🗆 No of Vital 1 ☐ Yes 2 N 1 ☐ Yes 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 \( \to \) Nursing Home \( 5 \) Residence \( 6 \) Detrier (Specify) 2 N 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To DOVE 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division HOUSE or Attending 5 Pending investigation 1 Natural hours after death. 1 ☐ Yes 2 ☐ No 2 Accident I Director: d in by the f 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral DI 29a. Certifier 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29d. Date signed (Month, Day, Year) 09-21-2009

JO State

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

ss of person who completed cause of death (Item 23a) (Type, Print) 349 Malcoly duke, West minutes MD LAMAN B KANERTA 349 Malcoly duke, West minutes MD 2115

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Laird Helen G. 2009 12:21 21, September 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Wicomico Parsonsburg 7217 Broad Street Birthplace (State or Foreign Country)
 Maryland 8. Date of Birth (Month, Day, Year) 04/20/1918 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under Days 1 □ M 2 🔀 F 91 215-94-2575 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 ¥Yes 2 □ No Parsonsburg Maryland Wicomico 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21849 USA 7217 Broad Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 □ Yes 2 👿 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2X No Specify: white 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) domestic housewife 5 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maggie Lively George Laird 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7127 Broad St., Parsonsburg, MD 21849 Robert Hurley/son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Wicomico Memorial Park Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 9/25/09 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Foneral Service Licens 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) CHF. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Vear Day in the past 12 months?
1 Yes 2 No 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Unknown 2 □ No 3 □ Probably

Examiner To the Hospital or Attending PhysIcian: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, signed by the a d be detached f icate has been si, page 2 should b this certifical After n 24 hours after death.

Ne Funeral Director: Af

Physician

/Medical

**Examiner** 

**Funeral** 

Director

ral", or items 23a or 28a-f show

Pages 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or ite ury or other traumatic event, Ite Madical Externines

Department of Important: If it any Injury or conce.

Physician /Medical

Baltimore, Maryland 21215-0036

death with the

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

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Completed

Be

Certification: To

Medical

								opsy formed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No			
25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No		26. Place of Death (Check only one)										
		Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify)										
27. Manner of Death  1 Natural  2 Accident	5 Pending investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		c. Injury at Work? 1 □ Yes	2 🗆 No	28d. Describ	28d. Describe how injury occurred				
3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, fa	actory, o	office		28f. Location City or T	8f. Location (Street and Number or Rural Route Number, City or Town, State)				
29a. Certifier (Check only one)	1 → Certifying Ph 2 ☐ Medical Exam	nysician: To the best of my kno niner: On the basis of examina and manner stated.	owledge, death occ ation and/or investig	urred a gation, i	t the time, in my opini	date and plac on, death occ	ce, and due to the curred at the time	ne cause(s e, date and	) and manner as stated. d place, and due to the cause(s)			
29b. Signature and t	itle of certifier			29c.	License nu	ımber		29d. Da	te signed (Month, Day, Year)			

WINTERPLACE PKWY, SAlis, MD 21804

State Registrar

DHMH 17 Rev 1/2001

within 2 To the I

Name and address of person who completed cause of death (Item 23a) (Type, Print)

		4	For State	State of Mary		artment of Hetificate of L			giene Reg. No.	98	82180		
			Registrar  1. Decedent's Name (First, Middle, Last	timodito of E	, , , , , , , , , , , , , , , , , , ,	2. Date of Death			3. Time of Death				
	Physicia	an						Month Day Year September 26 200			8:01 P <sup>M</sup> _		
	/Medic	al -	Mary Elizabeth	4h City Tours of	Location of Death	4c. County of Dea			0.01				
,	Examin	er	la. Facility Name (If not institution, give				_						
			Garrett County Me		ital yrs. last birthday)	Oakland If Under 1 Year	d. If Under 24 Hrs.	8. Date of Birtl	Garrett		hplace (State or Foreign		
	Funeral		5. Social Security Number 6. Se	TM ONTE	Yrs. last birtilday)	Months Days Hours Min.		(Month, Day, Year)		Coui	ntry)		
	Director		219-14-6594 Usual Residence of Decedent	86		L		03/29/	1923	riai	yland		
	and w		10a. State 10b. County	100	c. City, Town or Lo	cation					10d. Inside City Limits		
ife, Maryland Z I Z I D-UU30 s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, the Mudical Examinar must be notified at	sho		MD Garrett Oakland								1 Yes 2 No		
	ect	MD Garrett  10e. Street and Number	10f Zin Code	10f. Zip Code			of What Cou	ntry?					
	늅							-					
	Funeral Director	5 E. Mason Street	12. Was Decedent Ever	in HS 13 V	21.550 Was Decedent of Hi	ienanic Origin? (Sp	ecify Yes or No-		ed Star Race - Ameri				
	une	11. Marital Status	Armed Forces?	13.	f Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)		Black, White, etc.				
5	within 72 hours after ene. than "natural", or Ite	by F	1 ☐ Never Married 2 ☐ Married ☐ 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🔀 No	Specify:		Sp	ecity:	ito		
2-0030	hour		15. Decedent's Edi		16a Dece	dent's Usual Occupa	ation		16b Kind	White  Kind of Business/Industry			
<u> </u>	na 72	Completed	(Specify only highest grad		(Give	kind of work done of DO NOT use retired	ing						
V	Mithin 1990.	E	Elementary/Secondary (0-12)	College (1-4or 5+)		emaker			Own Home				
Z	led Hygle her nt, it		17. Father's Name (First, Middle, Last)		Home	JIII AKCI	18. Mother's Nam	Name (First, Middle, Maiden Surname)					
and	be f d of eve	Be											
Via Ouid Men Men Men Men Men Men Men Men Men Men		은	Gordon McRobi		10h Maille	- Address (Street	Mary		ller	Town, State, Zip Code)			
Maryland Z d 2 should be filed w th and Menial Hygle i? is marked other ti trsumatic avent, ID		19a. Informant's Name/Relationship (7			_								
d)	lealth m 27 i	ļ	John R. Mosser, S 20a. Method of Disposition		2940 20b. Place of Dispo	3 Oakland				tion - City or T	21.550 own, State		
5	ges if its or of		1X Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, crei	matory or other plac		Date 0/2009					
Ē	men tant: jury	1	4 □ Donation 5 □ Other (Specify			Memorial (			0akl	and, M	D		
saltimore	permit. Pages 1 and Department of Healt Important: if item 2 any injury or other pnce.		21. Signature of Funeral Service Licen.	see 	22	2. Name and Addres David A	• Burdock	Funera	1 Hom	e, P.A	<b>.</b>		
	40 = 4 a		22. Name and Address of Facility  David A. Burdock Funeral Home, P.A.  21 N. Second St., Oakland, MD 21550  One of Facility David A. Burdock Funeral Home, P.A.  Approximate										
Physician /Medical		Shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition								Interval Between			
										WHARS			
			resulting in death)	Due to (or as a co	onsequence of):								
Examiner		Examiner	Sequentially list conditions, b.										
P #	if any, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):												
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9	artific ing p	Med	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?  4 Pregnant at time of death 5 Other (specify)							23d. Date of delivery  Month Day Year			
Box	leath certifica attending pt I for use as ti	Physician/Me											
	The taw requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Sici											
0	res that the de signed by the a be detached f	£	9 LUnknown								the cause of death?		
ś	res th	ρ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use cor							No 3□Pro	3 ☐ Probably 4 ☐ Unknown		
5	w require been sign	ted	I'M ABGREE GEAT DIVE										
ပ္	taw tas b	Completed						24a. Was	OSV	prior to d	topsy findings available completion of cause of		
<u> </u>	nysician: The faw nis certificete has I I director, page 2 s	Son						1 ☐ Yes	ormed? 2 No	death?	2 🗆 No		
Ħ	striffic ctor.	Be	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only	опе)				
<u>ج</u>	ysic li dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 ER/Outpatie		4   14013mig 11	ome 5 Res			cify)		
0	Attending Physician: or death. ector: After this certification is the funeral director.		27. Manner of Death  1 ☐Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	ear) 28b. Time o	Wor		28d. Describe	how injury	occurred			
<u>ত</u>	death. ctor: Ay y the fu	Certification:	2 ☐ Accident investigation		M 1 ☐ Yes 2 ☐ No  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)				28f. Location (Street and Number or Rural Route Number, City or Town, State)				
Division of Vital Records,			3 ☐ Suicide 6 ☐ Could not be determined	286. Place of Injury									
Ω	ital o irs eft rai Di led in												
	To the Hospital or Attending Ph within 24 hours efter death.  To the Funaral Director: After thi completely filled in by the funeral	Medicai	29a. Certifier (Check only (Ch										
	thin 2 the mplet	Med	29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)										
	5 × 5 0		200. Signature and the or certific	10/ h 10 NOS(1411) 01/77/9									
		5											
		3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Lev Buczynski Mil, 3M Mi 4 4 57, Suite Cause of death (Item 23a) (Type, Print)										
			31. Date filed (Month, Day, Year) 32. Registrar's Signature										
	St Regist	ate rar	SEP 3 0 2009 A										
			VEI UV E	Rama	1 13. 19	Carlotte							

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 16 2009 **Physician** 4:25p September Mielke Vernon Walter /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carrol1 Carroll Hospice Dove House Westminster If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Aug 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** Months Days Hours Min. 1 1 M 2 □ F MD Aug 219-22-9373 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Event in the modified at 1 □Yes 2 □ No Sykesville MD Carroll Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or any injury or other traumatic event, the Medical Evin that must be a once. USA 21784 6161 Oakland Mills Road Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 NYes 2 No WWII If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: white ď 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) aerospace Elementary/Secondary (0-12) College (1-4or 5+) aerospace engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sadie Brown William J. Mielke 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6161 Oakland Mills Rd., Sykesville, MD 21784 Marian W. Mielke (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Sykesville, MD 9-21-09 Lake View Memorial 4 Donation 5 Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel] 21. Signature of Funeral Service Licenses Dage Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a, Part1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending PhysIclan: The law requires that the death certificate be executed inding physician and use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day for Month Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🖪 No 2 🗆 No 1 ☐ Yes 1 □ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? 1 ☑ Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: 

completely filled in by the fu 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 Medical Examiner; (Check and manner stated. To the 29d. Date signed (Month, Day, Year) 29b. Signatu and title of certifier Name and address of person who Stroot Woshinister, HD 21157 awio truto 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month 4:26  $P^{M}$ 9/16/2009 ALTHRA RUTH MOCK 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death PRINCE GEORGE"S PRINCE GEORGE"S HOSPITAL CHEVERLY 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number Months Days Hours 1 □ M 2 🕅 F 10/30/1936 Conway, SC *579-50-9400* Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 XYes 2 No Washington DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20032 1216 Savannah Street SE 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Black 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Government Mail Room Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Parmlev Estella Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Cassandra Mock Glover / Daughter 5813 Jackies Way Clinton, Maryland 20735 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Repyoval from State 4 Donation 5 Other (Specify) 9/24/2009 Clinton, Maryland Resurrection 21. Signature of Funeral Service Lice 22. Name and Address of Facility Pope Funeral Homes, P. A. 5538 Marlboro Pike Forestville, Maryland complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arra p oximate erval Between nset and Death 23a. Part 1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 □Yes 2 No 1 ☐ Yes Hospital:

Division of Vital Records, P.O. Box 68760

**Physician** 

/Medical

Examiner

**Funeral** 

Director

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Department of Health Important: If Item 27 any injury or other to once.

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Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

√ Physician disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, it and the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar aftending physician for use as the buria Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ÛNo 9 ☐ Unknown been signed by the should be detached þ Completed s certificate has t irector, page 2 sl funeral director, 25. Was case referred to medical examiner? Be 1 Yes Medical Certification: To Date of (Month, 27. Manper of Death After 1 Natural 5 Pending investigation ours after death. Accident 3 Suicide 6 ☐ Could not be 28e. Place of building 4 🗌 Homicide 24 hours a 29a. Certifier within 24 ho

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oatient 2 🗆	ER/Outpatient	3 ☐ DOA	Other: 4 Nursing H	ome 5 ☐ Residence 6 [	Other (Specify)
Injury Day, Year)	28b. Time of Injury	28c	Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury o	ccurred
Injury - At he , etc. (Special	ome, farm, stree	t, factory, o	ffice	28f. Location (Street and f City or Town, State)	Number or Rural Route Number,

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

one)	and manner stated.	vestigation, in my opinion, death occurred at the	time, date and place, and due to the cause(s
9b. Signature and tit	Te of certifier	29c. License number	29d. Date signed (Month Day, Year)

31. Date filed (Month, Day, 2 4 2009

State Registrar

State Registrar

31. Date filed (Month, Day, SEP 2 4 2009

32. Registrar's Signature face

Division of Vital Records, P.O. Box 68760

Registrar DHMH 17 Rev 1/2001

State

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31. Date filed (Month, Day, Year)

07

2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

625

32 Registrar's Signature

Evelyn Mossburg State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 2305 hrs Evelyn Virginia Mossburg **Medical Examiner** September 30, 2009 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Frederick Rt. 17 at Rosemont Drive Brunswick 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number If Under 1 Year If Under 24Hrs. **Funeral** Days 212-38-7749 73 Months Hours May 4, 1936 Director Maryland М Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County Maryland Frederick Yes 2 X No Frederick or items 23a or 28a-f show must be notified at once death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21702 9411 Boulder Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black. 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? Never Married Married Yes 2 X No Specify: White Pages 1 and 2 should be filed within 72 hours after 3 X Widowed Divorced If Yes, Give Year Yes 2X No specify: narked other than "natural", event, the Medical Examiner <u>δ</u> 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Completed Flementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Government Housekeeping 10 ant of Health and Mental Hygiene.

It if item 27 is marked other the 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charles W. Stine Ruth Heffner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Preston E. Mossburg III, son 9411 Boulder Road, Frederick, MD 21702 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, Resthaven Mem. Gardens Oct. 5, 2009 Frederick, MD 1 X Bunial 2 Cremation 3 Removal from State Donation 5 Other Specify. 21. Signature of Funeral Se i e Licenses <sup>22</sup>Keeney and Fbasford PA Funeral Home 21701 MO0255 106 East Church St., Frederick, MD Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** failure. List only one cause on eath line Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit The law requires that the death certificate be executed Physician/Medical physician a UNPENDED AMENDED Box 68760. IE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atter 1 Yes 2 No 9 V Unknown Unknown 23e. Did tobacco use contribute to the cause of death? P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, certificate has been sector, page 2 should 24b. Were autopsy findings available 24a Was an prior to completion of cause of autoosy death? ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient 2 DOA Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 this 1 Yes 2 No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 27. Manner of Death Certification: Passenger auto collision Sep 30, 2009 2245 hrs 1 Natural Director: Yes 2 ✔ No Pending hours after death. 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) Rt. 17 at Rosemont Drive, Brunswick, MD within 24 hours at To the Funeral L determined (Specify) Major Road / Highway 4 Homicide completely Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier October 1, 2009 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Ana Rubio MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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Physicia		1. Decedent's Name (First, M		1						· T	2. Date of Deat		3	. Time of Death .
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()		4a. Facility Name (if not insti Rt. 17 at Rosemon	_	reet and nur	mber)	1	4b. City, 1 Bruns		ocation of	Death		4c. County of Frederick		
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs. I	last birthday)		er 1 Year	If Under	24Hrs.	8. Date of Bir			place (State or Foreign
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hours fuatur Exam		15. Decedent's Education (				16a. Deceden during m			on (Give kl DO NOT u			16b. Kind of Busi	ness/Ind	lustry
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21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Con	17. Father's Name (First, Mic	idle, Last)					16	B. <b>Mother'</b> s	Name (	(First, Middle, N	Maiden Surname)	0, 110	- Indending
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D 21 Should Should Me Ind Me I is ma	입	19a. Informant's Name/Relation Preston E. M			son							nber, City or Town, , MD 217		Zip Code)
h, MD and 2 sha lealth and tem 27 is		20a. Method of Disposition		8 111	<u> </u>	Place of Dispos				LT	Date	20c. Location - C		own, State
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiente Important: If item 77 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 X Burial 2 Crem		Removal fro	om State	crematory or oth	ner place)	)	1	Oct	5 20	09 Fred	•	
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Box 6 e death ce the attend ed for use	∵ <u>o</u>		Linkson		ant at time of de	eath 5 Ot	her (Spe	cify)				Î		
<b>B. B</b> the de by the ched f	Phy	Part II. Other significant co		9 Unkno		resulting in the u	underlying	ı cause gi	ven in Par	t I.	23e. Did to	bacco use contrib	ute to th	e cause of death?
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tal Records cian: The law requi certificate has been sector, page 2 should	din										autop perfo	rmed? de	ath? ✓ Yes	mpletion of cause of
tal Rec	Be	25. Was case referred to me	dical					26.Place	of Death (6	Check o		2 110	163	210
Vita hysici this ce	0	examiner? 1 ✓ Yes 2 No	Hos	pital: 1 📗 li	npatient 2	ER/Outpatient	3 🗌 🛭	OOA C	Other 4	Nursing	Home 5	Residence 6	Other: S	Scene
<b>-</b> - ~ 2	H H	27. Manner of Death  1 Natural 5		28a. Date (Month, Sep 30,	of Injury Day Year) 2009	28b. Time of I 2245 hrs	njury		at Work?	Ir	28d. Describe l Driver auto	how injury occurre collision	d	
Jivision I or Attendi after death. I Director:	äţ		Pending Investigation			nome, farm, stree	ot footon	_	es 2 🗸 i		20f Location (	Ptropt and Number	or Dura	Deute Number City
Division all or Attendir is after death.  al Director: A led in by the fu	ertification:		Could not be determined			idile, lami, street ad / Highway		, onice bu	iliuing, etc		or Town, S			Route Number, City
Hospi 24 hou Funer ely fil	0	202 Cortifier	g Physician			<del></del>		time, dat	e and plac			se(s) and manner a		
Divisior  To the Hospital or Attend within 24 hours after To the Funeral Director: completely filled in by the I	Medical	(Orlook only	Examiner: Or		of examination a	-						and place, and du		
F ≥ F 3	M	29b. Signature and title of ce					290	c. License				29d. Date signed		h, Day, Year)
		uves						O.C.N	1.E.			October 1, 2	2009	
= 1		30. Name and address of pe Ana Rubio MD.	rson who com Assistant I		•	<sup>n 23a)</sup> 111 Penn S	Street F	Baltimo	e MD :	21201				
St	ate	31. Date filed (Month, Day Y			gistrar's Signat		ار المحمد	20.011101	J, WID 2	- 1201				
Regist	trar	TOT	77 200	3 /2	تهس	p. 1990								

State of Maryland / Department of Health and Mental Hygiene State
Registrar AMEND#2perMD, 10-1-09, EMW, MoCo Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Da 22 **Physician** SEPTEMBER <del>21</del>, 2009 Neumann 2106 Irmgard /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 5. Social Security Number **Funeral** Year) Days Hours 1 □ M 2 🛣 F Months FEB 06, 1922 Germany 033-38-9057 87 **Director** Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the "Modical Examinations to provide at 1 ☐ Yes 2 1 No Director Maryland Montgomery Bethesda 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code 20817 United States 9213 Vendome Drive Funeral hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 □ Never Married 2 □ Married Specify: Caucasian Baltimore, Maryland 21215-0036 1 ☐Yes 2X No Specify þ 3 M Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/industry and 2 should be filed within 72 U.S. Department of permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Mean injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Commerce Economist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hartmann (UNAVAILABLE) Walter ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9213 Vendome Dr., Bethesda, MD 20817 Eva Neumann / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 09/26/2009 Glen Burnie, Maryland Atlantic Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Thibadeau Mortuary Service, P.A. 21. Signature of Funeral Service Spring, MD 20910 M001508 933 Gist Avenue, LL, Silver Approximate Interval Between Onset and Death 23a. Part 1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician a. ACUTE ARRHYTHMIA MINUTES disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner MINUTES b. CARDIAC ARREST Sequentially list conditions, if any, caung to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disa to (or as a consequence of) Examine requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) signed by the a 1 ☐ Yes 2 🔯 No P.0. 9 I Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Attending Physician: 26. Place of Death (Check only one) director, 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XNo 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: Ai completely filled in by the fu 1 ☐ Yes 2 ☐ No death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Pate signed (Month, Day, Year) of certifie 29b. Signature and title ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and adds MO-9901 Medical Center Dr., Rockville, Mb. 20850 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month September Day Year **Physician** 725 M AINE IECESA ( 2009 /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner onal medical WICOMICO If Under 24 Hrs 8. Date of Birth (Month, Day, Year 7. Age (In yrs. last birthday) (State or Foreign **Funeral** 1□M 2**X**F Months Days Hours Min. 208-44-3987 Usual Residence of Decedent Director death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examiner must be political at 1 ☐Yes 2 ☐ No Director BIVALLE Wicomico 10g. Citizen of What Country? Street and Number 10f. Zip Code BWALVE USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 10 14. Race - American Indian 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: þ Specify: WHITE 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than 'eny Injury or other traumatic event, Item once. Elementary/Secondary (0-12) College (1-4or 5+) MEMAKER OWN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELEANOR (LIGER KARPINBKI ၉ 19a. Informant's Name/Relationship (Type. Pr. t) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2085 BIVALVELODGE AD MD 13/8/14 (MERAND 20c. Location - City or Town, State 10M OUTTEN 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Sausbury MD 21801 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. MESSICK FUNERAL HOME PO BOKO BIVALVE, MODAISIY Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Hinknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 🗆 N 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 □ M6 1 phopatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 atural 1 ☐ Yes 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

614

2/804

State of Maryland / Department of Health and Mental Hygiene

			For State of Maryland / Dep	rtificate of Death	Reg. N	0000 0010
	Physicia	an	1. Decedent's Name (First, Middle, Last)  RICHARD GOULD PHELAN		2. Date of Death Month September	3. Time of Death 23, 2009 4:00 A <sup>M</sup>
d'	/Medic Examin	al	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Death
1	LAAIIIII		Shady Grove Adventist Hospital	Rockville		Montgomery
	Funeral Director		5. Social Security Number 244-42-1084 6. Sex 1 ☑ M 2 ☐ F 76 Yrs.	If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Yea June 18,1	9. Birthplace (State or Foreign Country) Pennsylvania
	land ow	1	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or L	ocation		10d. Inside City Limits
	la-f sh	ctor	MD Frederick New Mar			1 □Yes 2 No
	th with the 23a or 28 and 15 a	Funeral Director	10e. Street and Number 5751 Applefield Path	10f. Zip Code 21774	Un	Citizen of What Country?  ited States
Maryland 21215-0036	filed within 72 hours after death with the Maryland Hygiene. yther than "natural", or items 23a or 28a-f show ant, if w Madical Exact har out be notified at	þ	1 □ Never Married 2 ⚠ Married 3 □ Widowed 4 □ Divorced  1 ☒ Yes 2 □ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 □Yes 2X No Specify:		14. Race - American Indian, Black, White, etc.  Specify: White
15-0	"natu	lete	(Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work DO NOT use retired)	dna I	Kind of Business/Industry nternal Revenue
212	filed withir Hygiene. other than ent, the M	Completed	Elementary/Secondary (0-12) College (1-4or 5+) Pers	sonnel Management Specialist	1	Service
pu	be filed water Hygie of other tevent, It	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, Maid	en Surname)
yla	d Meni d Meni narked natic e	ဥ	James Phelan	EIIZab	eth Gould	y or Town State Zin Code)
Mai	s 1 and 2 should be fill of Health and Mental H item 27 Is marked oth other traumatic even			. Applefield Path		et, MD 21774
ore,	of Hea		20a. Method of Disposition 20b. Place of Disposition	position (Name of		Location - City or Town, State
<u>m</u>	Page ment ant: If ury or		4 Donation 5 Other (Specify) Metropol	itan Crem.	$\frac{1}{009}^{23}$ , A	lexandria, VA
Baltimore,	permit. Pages 1 Department of H Important: If ite any injury or otl ance.			22. Name and Address of Facility De 10 East Deer Park	Vol Funera Dr. Gaithe	1 Home rsburg, MD 20877
			23a. Part 1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Congestive Heart	Failure		
7	Examiner		Chronic Obstructi	ive Pulmonary Dise	ase	
	p ±	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  Atrial Fibrillati			
2	tificate be executed ig physician and as the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C. Atrial Fibrillat:  Due to (or as a consequence of):	Lon		
68760,	e be ex sician		d			
	- O 6	<b>l</b> edical				
O. Box	To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Physician/M		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
٩,	s that gned by e deta		Part II. Other significant conditions contributing to death but not resulting in the		23e. Did tobacc	co use contribute to the cause of death?
ord	equire sen siç ould b	ted k	Gastrointestinal Bleed, Diabetes Mel	llitis, Anemia,	1 Tes	2 X No 3 Probably 4 Unknown
I Records,	:The law r cate has be page 2 sh	Completed by	Prostate Cancer		24a. Was an autopsy performed 1 □Yes 2 🏋	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No
of Vital	ician: certific ector,	Be (	25. Was case referred to medical examiner?  Hospital: Hospital:	Othor	ath (Check only one)	
of	Phys r this ral dir	- To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	lome 5 Residence	e 6 Other (Specify)  njury occurred
ion	nding ath. r: Afte e fune	ation	1 XNatural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 □Yes 2 □No		
Division	af or Atter s after des I Director d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, so building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	t and Number or Rural Route Number, tate)
	ne Hospit n 24 hour ne Funera	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and plac investigation, in my opinion, death occi	e, and due to the caus urred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)
	Vithii To th	Me	29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
	10		Genell Wille	D0069336	Se	ptember 23, 2009
	•		30. Name and address of person who completed cause of death (Item 23a) (Typ Dr. Janelle Williams M.D. 9901 Mg	edical Cemter Dr.	Rockville,	MD 20850
	St	ate	21 Date filed (Month Day Vear) #22 Registrar's Signature			
	Regist	rar	SEP 24 2009 Seven B. Jan	Kad.		

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ipit triioj i ou.	1-	For State Certificate of Death	Reg. N	lo. 6 U	3. Time of Death
Physicia		egistrar . Decedent's Name (First, Middle,Last)	Date of Death     Month Da     September 1	y Year	0703 hrs
edical Examir	er	Ralph Wiley Pearce		4c. County of Dea	ath
	4	a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death Clinton  Clinton		Prince Georg	
		Southern Waryland Huspital	. 8. Date of Birth (N	M/DD/YYYY) 9. E	Birthplace (State or
Funeral	,	Social Security Number 6. Sex 7. Age (iii yis. last blittley) Months   Days   Hours   Min.	-	For	eign Country) IL.
Director		312 56 6865   1XX <sub>M</sub> 2 F 60 Yrs.   William 1	Aug 9,	1747	11.
*	<u>ا</u> ــ	Jsual Residence of Decedent  Oa. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
ow any	1	oa. State			1 Yes 2XX No
Aaryland 28a-f show 1 at once.	Director	Maryland Prince George Upper Marlboro  [Oe. Street and Number]  10f. Zip Code	10g.	Citizen of What C	ountry?
th the Mary 23a or 28a notified at	<u>ë</u>		Ţ	Jnited St	ates
23a notif		9905 TRATE DOTO TIRE	pecify Yes or No-	14. Race - An White, etc	nerican Indian, Black,
ath w	Funeral	1 Never Married 2 XX Married Armed Forces?	rican, cic.,		
her de		3 Widowed 4 Divorced If Yes Give Year Vietnam 1 Yes 2XX No specify:		Specify: Wil-	
hours after death w "natural", or items <u>Examiner must be</u>	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use relationships to the complete of the c		bp. King of busine	ss/industry
5 72 hc in "ng	et	Elementary/Secondary (0-12) College (1-4 or 5+) 12 Airforce		Govern	nment
030 vithin ene.	ompleted	To the state of th	e (First, Middle, Ma		
15-C	CC	17. Father's Name (First, Middle, Last)	Alta Bou	lware	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	മ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or	Rural Route Numb	er, City or Town, S	itate, Zip Code)
	۲	Mary Pearce (Wife) 9903 Malboro Pike, l		lboro, MI	20772
and 2 fealth tem 2		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 9-2	25-2009	20c. Location - Cit	
MOFE Pages 1 nent of F ant: If i		1 X Burial 2 Cremation 3 Removal from State Maryland Veterans Cemeter	ry	Chelten	nam, Maryland
Baltimore, permit. Pages I as Department of He Important: If ite	. 3	4 Dogation 5 Other Specify: 1  21. Significant of up of project of the specific of the specifi	e Funeral	Home, In	nc 6633 01d
Ba Perm Depa Imp	8 8	23a. Part J. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac	Road, Cli	nton, MD	20735 Approximate Interval
Physician	_	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arres	st, snock, or near	Between Onset and Death
'Medical		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease			Deali
aminer		or condition resulting in death)  Due to (or as a consequence of):			
	_	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):			
	ine	cause. Enter Underlying Cause			
d sit	Examiner	events resulting in death) Last Due to (or as a consequence of):			
68760, certificate be executed anding physician and se as the burial - transit	ज	d. INPENDED AMENDED			
tal Records, P.O. Box 68760, cian: The law requires that the death certificate be excerificate has been signed by the attending physician pane? Should he detached for use as the burial-	Physician/Medic	On Liver		23d. Date of d	
376 ificate	₹	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pre	gnancy	Month	Day Year
	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
Bo e deat	l k	1 Yes 2 No 9 Unknown g Unknown  Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contrib	ute to the cause of death?
hat the red by	2		1 Yes	2 No 3	Probably 4 V Unknown
S, T	Completed by		24a. Was		ere autopsy findings available for to completion of cause of
ord w req	l e			rmed? de	eath?
Rec The la		26.Place of Death (Ch	1 Yes	2 NO	Yes 2 No
tal Rec	B B	25. Was case referred to medical	ursing Home 5	Residence 6	Other:
Division of Vital Records, P.O. Box 68760, rat or Attending Physician: The law requires that the death certificate be as fler death.  The this certificate has been signed by the attending physic all Director: After this certificate has been signed by the attending physic at the control of the control page as the but	il c	1 Yes 2 No		how injury occurre	ed
ing Ph	غ ا				
Divisior pital or Attend ours after death eral Director:	ortification.	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (	Street and Number	er or Rural Route Number, City
Divis	1	3 Suicide 6 Could not be determined (Specify)	or Town,	State)	
ospita hours	ا د	293 Certifier The transfer of multipopulation death occurred at the time, date and place,	and due to the cau	se(s) and manner	as stated.
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte	completely	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place.  (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur	red at the time, date	Cita pinary	
To To	Modical	29b. Signature and title of certifier  29c. License number		29d. Date sign	ed (Month, Day, Year)
	1	O.C.M.E.		September	20, 2009
0 1.		30. Name and address of person who completed considerable (item 23a)			
B55	16	Pussell Alexander MD Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201		
	Sta	e 31. Date filed (Month, Day, Year) SEP 23 2009 32. Registrar's Signature for SEP 23 2009			
Reg	istr	TEP 20 2003   permit /			

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 23a per phys 6396 10//09 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month 4:33 M **Physician** Destinee 09 2 9-2009 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner of Mayland Medical (enter Inversity Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 😾 F 9-16-1995 Director 215-45-8526 MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene.
It if item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it is "walked it is not or other traumatic event, it is "walked it is not in it." Y⊟Yes 2 □ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 1837 E. 29th Street 21218 U S Α Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2√√No If Yes, Give Year or Dates: 1X Never Married 2 ☐ Married Maryland 21215-0036 Black 1 ☐Yes 2 XNo Specify. þ 3 Widowed 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) School 8th grade N/A Student 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James W. Parker, Jr Kim Tate ౖ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1837 E. 29th Street James W. Parker, Jr-father Balto, MD 21218 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Pages 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or once. King Memorial Pk 10-3- 09 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March East F/H 21. Signature of Funeral Service Licensee 21202 1101 E. North Avenue Baltimore, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) & duy Physician Anones /Medical Due to (or as a consequence of): Examiner Respiratory Sequentially list conditions days Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed Intection HINI and burial-trai Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 ☐ Other (specify) detached 9 Unknown 9 4 Onknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ cate has been sign page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy Hospital or Attending Physician: The performe ueatn? 1 □ Yes 2 🗹 No 2º☑No 1 ☐ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 🗖 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A 2 Accident filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 • Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) completely and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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Timmons

<sup>Year)</sup> 2009

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31. Date filed (Month, Day,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 30 Month :10a M **Physician** eptember omas 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City**  Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) Nov 3, 1957 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Hours Min 1 XM 2 F MD 213-72-4476 51 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nert of Heatth and Mental Hygiene.

nt; If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. Cour 10c. City, Town or Location ortant; If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Allegany Cumberland MD 1 □ Yes 2 □ No Director 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Numbe 21502 USA 517 Louisiana Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black White etc 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Baltimore, Maryland 21215-0036 Specify. If Yes, Give Year or Dates: Specify: 2 white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Lieutenant Correctional Officer Prison 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Kenneth M. Perry Mary G. (Mencer) Perry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Monette Perry 517 Louisiana Avenue Cumberland MD 21502 wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Scremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Scarpelli Funeral Home, P.A. 20c. Location - City or Town, State Date 10/1/200 MD Cresaptown 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only the cause on each line. Approximate Interval Between 23a. Part/1 Enter the disea show, or heart failure Onset and Death Immediate Cause Final **Physician** CSU hour-1 VUTICUdisease or condition resulting in death /Medical Due to (or as a consequence of) Examiner 1+cpn+itis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed burial-trar and Due to (or as a consequence of) attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Live birth Month Day Year 4 Pregnant at time of death
9 Unknown 5 Other (specify) 2 No the 9 Unknown has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 3 Probably 4 Unknown 1 Tes 2 No filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 25. Was case referred to medical 26. Place of Death (Check only one, Be Other: 4 \sum Nursing Home Hospital: 2 ER/Outpatient 3 DOA 1 ☐ Yes 2. Z No 1 Xinpatient 5 Residence 6 Other (Specify) မ 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury Certification: (Month, Day 1 Natural 2 Accident 5 Pending investigation 1 🗌 Yes 2 🗌 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide Could not be 4 Homicide

Division of Vital Records, P.O. Box 68760, or Attending Physician: within 24 hours after deat To the Funeral Director:

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Registrar's Signature 31. Date filed (Month 32

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1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2009 Suptomber

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

Medical

(check only

29b. Signature and title of certifier

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State of Maryland / Department of Health and Mental Hygiene 🤉 Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** 8:00 A SEPTEMBER 20 2009 JONATHAN JOSEPH RUDD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FREDERICK FREDERICK MEMORIAL HOSPITAL FREDERICK 9. Birthplace (State or Foreign Country)
New York If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Feb. 2, 6. Sex 7. Age (In vrs. last birthday **Funeral** Hours 1**∑** M 2□ F Months Days 156-24-2702 80 Yrs Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Macilcal Examinar must be notified all 1 ☐ Yes 21 No Director Maryland Frederick Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Export Permit Permonde. U.S.A. 5990 Grove Hill Road 21703 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛂 No Specify: Specify: Year or Dates: Korean White Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Farming Supply Store Farmer's Cooperative 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Rose Janacek Bertrand Rudd 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5990 Grove Hill Road, Frederick, MD 21703 Cynthia Regner / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg, Maryland Smithsburg Crematory | 9/21/09 4 □ Donation 5 □ Other (Specify) OBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. small Bouel Immediate Cause (Final disease or condition resulting in death) Objlued to DAYS **Physician** /Medical Due to (or as a consequence of) Examiner DAYS Ileus Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed burial-tra Due to (or as a consequence of): attending physician for use as the buria Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown been signed to should be deta 23e. Did tobacco use contribute to the cause of death? Part LOther significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ PAKIDSONI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has le 2 s page After this certificate funeral director, pag 1 ☐Yes 2 X No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 27, Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation Division death. 1 ☐ Yes 2 ☐ No filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide after within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 29c. License number DOOK 2223 ss of person who completed cause of death (Item 23a) (Type, Print) 196 TT DLIVE , FREDELICE, PRAYERY BOCARUM MD 31. Date filed (Month, Day, Year) 32., Registrar's Signature State Registrar

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permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other trai		21. Signature of Fu		Supition .		22	Name and Addre David A	ss of Facility Burdock cond St.	Funera	1 Ho	me, P.A	<b>5</b>
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To ti withi To ti	Ĭ	29b. Signature and	title of certifier	ta Ka	m-	W	29c. Licens	e number 26650	,	29d. Da	te signed (Monti	h, Day, Year)
מעו	2	30. Name and addr	ess of person wh	o completed cause of d	leath (Item 23	la) (Type,	Print)	1	17	10	1 /	1/3.55
I V P Sta	ン te	31. Date filed (Mon	th, Day, Year)	CUSC //	ar's Signature	20/	News	as He	· Va	WA	v4 1	W 2500
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. L. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) September 22, 2009 **Physician** 1:30 A Charles F. Reiter, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Westminster Carroll Hospital Center 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye July 11, Year) 1921 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 XM 2 □ F 212-16-3521 88 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f shov item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Carroll Hampstead Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21074 4747 Millers Station Road Funeral 12. Was Decedent Ever în U.S.
Armed Forces?
1 X Yes 2 No 194
If Yes, Give
Year or Dates: 194 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1943 within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: white <u>ک</u> 1947 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within nent of Health and Mental Hygiene. ant: If item 27 Is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) security guard 6 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Clara M. Lingner Charles F. Reiter, Sr. ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4747 Millers Station Road Hampstead, MD 21074 John Charles Reiter - son 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition Garrison Forest permit. Pages 1
Department of H
Important: If ite
any injury or ot Sept. 24, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Owings Mills, Maryland 4 Donation 5 Other (Specify) Veterans Cemetery 2009 Eline Funeral Home treet Hampstead, Maryland 21074 21. Signature of Funeral Service License 22. Name and Address of Facility M01072 934 South Main Street 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEFSIS **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner ONGESTIVE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Live birth 2 Fetal death Year Month Day in the past 12 mopths? 5 Other (specify) signed by the a 1 □Yes 2 ☑No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Frobably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a Was an certificate has birector, page 2 s 2 No 2 ANO 1 ☐ Yes 1 □ Yes within 24 hours after death.

To the Funeral Director: After this certiflic completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \( \) Nursing Home \( 5 \) Residence \( 6 \) Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d, Describe how injury occurred 27. Manner of Death Injury 5 ☐ Pending investigation 1 Natural 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

iculsur

RUCES

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

parks

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** estember 20 ee JCC 57 /Medical County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner tor's Community Hospita MINCE Under 24 Hrs. last birthday, **Funeral** Year) Months Days 1 □ M 2 🗗 F Hours 6 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Show ?7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Medical Examina, must be notified at 1 Yes 2 No Director MD ANGOVER George > 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20785 Funeral Was Decedent Ever in U.S. Armed Forces? 1 \_Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc filed within 72 hours after 1 ☐Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married /*OV* を */ (Var Y し*itimore, Maryland 21215-0036 1 □Yes 2 No à IACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) HEAD CASHIER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be pe Simon RODAL Pages 1 and 2 should ပ္ Gretrupe Glover and ! 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 Is any Injury or other traionce. ShellA Glover ANDOUGE MO 7512 Grouse 20785 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Memorial 9/25/2009 LANDOVER Harmony Memonia [19/20]20011200112001120015 4 ☐ Donation 5 ☐ Other (Specify) LANDONER MO 1713 Country was ct, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hypotension Physician disease or condition resulting in death) /Medical Due to (of as a consequence of): Examiner Hypoxic if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to ( Examine The law requires that the death certificate be executed burial-transit SIMMONUS resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending pl IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 mor Month Year signed by the a d be detached for 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably Unknown cate has been si page 2 should b Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performes certificate 2/ No Division of Vital 1·□Yes 1 ☐ Yes 2 ☐ No or Attending Physician: tter death. After this certification, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation -1 - Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

State Registrar

BEHT ASI 4 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

8118 GOOD LICK ROAD 32. Registrar's Signatur

MDD60925

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day Month **Physician** 22, September 12:25 A.M 2009 James Swanson Stidham /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery 12416 Viers Mill Road Wheaton

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Vear)

Months | Days | Hours | Min. | (Month, Day, Vear) 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F 70 Vrs Nov. 8, **Director** 223-46-7001 1938 Virginia Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nutified at once. 1 ☐ Yes 2 XNo Director Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12416 Viers Mill Road 20906 United States Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Xes 2 No 1955-If Yes, Give Year or Dates: 1968 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑ No ģ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Postal Elementary/Secondary (0-12) College (1-4or 5+) Service Carrier 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Almer P. Stidham Ella Jane Estep ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12416 Viers Mill Road, Wheaton, MD 20906 Celia Ann Stidham (Spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Mary s
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Rockville, Maryland etery 26, 2009 ROCKVIIIe 22. Name and Address of Facility DeVol Funeral Home, 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Sirvice L M00689 10 East Deer Park Drive, Gaz23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 10 East Deer Park Drive, Gaithersburg, MD 20877 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran Due to (or as a consequence of): P.O. Box 68760. Physician/Medical attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ Chronic Obstructive Pulmonary Disease 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Cirrhosis of Liver 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No cate has page 2 s 24a. Was an Coronary Artery Disease 2 **X**No 1 ☐ Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) 1∐Yes 2. No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After thir funeral c 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural Injury 5 Pending To the Hospital or Attendin.
) within 24 hours after death.
To the Funeral Director: Att

completely filled in by the fun investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number at 1 m D52252 September 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

24 2009

32 Registrar's Signature

Joseph A. Gebeily, M.D., 9715 Medical Center Drive, #501, Rockville, MD 20850

State

### State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Sept. Edward Nara Steele <u>Bazil</u> /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Garrett Garrett County Memorial Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Oakland Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** Months 1 XM 2 □ F 555-48-7390 8/13/1937 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10a. State 10b. County Director Oakland MD Garrett 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21550 N. 1st Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Specify: White 1 ☐ Yes 2 No 3altimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Entrepreneur 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Gladys Catherine Nara ဥ Bazil Edward Steele 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MD 21550 1st St., Oakland, Lillian Steele/ Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Country Side Crem. Davidsville, PA 4 □ Donation 5 □ Other (Specify) 9/30/09 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Newman Funeral Homes P.A. 203 S. 2nd St., Oakland, 23a. Part1. Enter the disease, or complications the shock, or heart failure. List only one cause of of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, acute febrile illness Immediate Cause (Final disease or condition **Physician** /Medical Examiner Physician/Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, within 24 hours at To the Funeral C

	resulting in death)	Due to (or as a conseque	ence of):				
dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last		mer 5 p	cystoprosta	rectony é	i leal loop	Sworths
ysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregnar 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	death 3 □Ectopic			23d. Date of de Month	livery Day Year
Completed by Physician/Medical	Part II. Other significant conditions of	_				2 No 3 P	or the cause of death?  robably 4 Inknown  utopsy findings available completion of cause of s 2 No
Be (	25. Was case referred to medical examiner?			26. Place of Dea	ath (Check only one)		
10E	1 Yes 2 No	Hospital: 1 Inpatient 2	R/Outpatient 3	DOA Other: 4 Nursing H	lome 5 Residence	6 □Other (Spe	ecify)
ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how in		
Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At hor building, etc. (Specify,	ne, farm, street, fact )	tory, office	28f. Location (Street City or Town, St	and Number or R ate)	ural Route Number,
Medical (		nysician: To the best of my know miner: On the basis of examinati and manner stated.					
Me	29b. Signature and title of certifier			29c. License number	29d.	Date signed (Mon	th, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

11:31 AM

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

days

1 X Yes 2 No

Washington

2009

U.S.A.

29d. Date signed (Month, Day, Year)

TIVE Oakland, MJ 21550

State Registrar 29b. Signature

th, Day,

Year)

30

(Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Evelyn Jeanette Shuck 2:05 SEPTEMBER 17 2009 Α /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** ALLEGANY CUMBERLAND WMHS-MEMORIAL CAMPUS If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth (Month, Day, Year) June 26, 1918 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 □ M 2 🕱 F 91 217-10-1394 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County show ral", or items 23a or 28a-f shov Examiner must be notified at 1 Yes 2 No Frostburg Director Allegany Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code **USA** 21532 One Kaylor Circle by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐ Yes 2 No Specify. Specify: White 3 Widowed 4 □ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry event, the Medical and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Silk Textile 8 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Maude Green James Fairgrieve ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 312 Fancy Filly Circle, Martinsburg, West Virginia, 25403 Health tem 27 is Thomas Kidwell - Son tem 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date September 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any Injury or otl
once. 1 ☐ Burial 2 ØCremation 3 ☐ Removal from State Cumberland, Maryland 17 2009 Cumberland Crematory 4 ☐ Donation 5 ☐ Other (Specify) Eichhorn-McKenzie Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lonaconing, MD 21539 P.A. 8 East Main Street Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Neumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Lause (Unsease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Year Month Day 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Š 1 ☐ Yes 2 ☐ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? certificate funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□Yes 2□No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation neral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I + Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical within 24 hor To the Fune completely fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Registrar

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

21

29c. License number

1:025 Kart Avenue, Cumberland, Mary land, Registrar's Signature

00033280

29d. Date signed (Month, Day, Year)

Sept 17, 2009

Physician: The law requires that the death certificate be executed Box 68760. P.0. or Attending

Baltimore, Maryland 21215-0036

Division of Vital Records, neral Director: / To the Hospital within 24 hours a To the Funeral C

31. Date filed (Month, Day, Year) State Registrar

4 Homicide

(Check only

30. Name and addr

29b. Signature and title of certific

determined

Arendun Henderson M.D. 32. Pegistrar's Signature

who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

295 Stever Ave. Wist miniter MP21178

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month 9:00 Edith Theresa Semerdjian 99 300 stember 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death CHARL MEDICAL If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country) ocial Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Min. Months 1 □ M 2√2 F 577-40-2976 77 1932 Washington DC Sept. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 X Yes 2 ☐ No Maryland Charles Indian Head 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 65 Circle Ave. 20640 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ∐Yes 2√∑ No Specify: White 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Credit Manager Coffee Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Melvin J. Selby Helen Margaret Marc 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Theresa L. Milburn Daughter 66 Circle Ave., Indian Head, Md. 20640 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 25, 2009 Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Clinton, Maryland 22. Name and Address of Facility 21. Signature of Funeral S Williams Funeral Home, P.A. Was M00668 4270 Hawthorne Road, Indian Head, Md. <del>20640</del> 23a. Part 1. Enter the dise shock, or hear failu se, or complications that aus aused he death. Do not enter the mode of dying, such as cardiac or Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or is a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) OV Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent prognant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Vear 5 Other (specify) 9 I Inknown 23e. Did tobacco use contribute to the cause of death? 14 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 □ Yes 2 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/No Hospital: 1 ☐ Yeş⁄ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐Yes 2 ☐ No Investigation 2 Accident

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

00

**Physician** /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

n and Mental Hygiene.

or other

rtant: If item

pernit. Page Deportment of Important: If any injury or onco.

s 1 and 2 should be fill f Health and Mental H tem 27 is marked ott

Pages 1

with the Maryland

death

filed within 72 hours after

Maryland 21215-0036

Baltimore,

/Medical

Director

Funeral

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Be Completed

2

Examine

Physician/Medical

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Be Completed

Certification: To

Medical

3 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

ON

31. Date filed (Month),

29b. Signature an

6 Could not be determined

Year)

Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ON

32/Registrar's Signature

and the attending physician as the for use detached ģ signed has director, this

Hospital or Attending Physician; The law requires that the death certificate be executed filled in by the funeral death. within 24 hours after deat To the Funeral Director:

Division of Vital Records, P.O. Box 68760,

State

1🔽 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License numbe

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

09-07610 Karen Swick Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2009 12202

		State of Maryland /	Certificate o	f Death			. No.	
Physician/	1.	Decedent's Name (First, Middle, Last)  KAREN SWICK				2. Date of Death Month September	Day Year	3. Time of Death 1305 hrs
al Examiner		KAREN SWICK  . Facility Name (if not institution, give street and number)		4b. City, Town, or	Location of Death	September	4c. County of Deaf	th
		Memorial Hospital		Cumberland			Allegany	(0)
Funeral	5.	Social Security Number 6. Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Day		7	(MM/DD/YYYY) g. B Fore	ian
Director	_	19-80-5009 1 M 2xF 50	) Yr			12-16-	1958	country) MD
any	_	sual Residence of Decedent  Da. State 10b. County	10c. City, Town or Loca	ation				10d. Inside City Lin
		MD ALLEGANY	CUMBERLAN	ID				1 X Yes 2
the Maryland a or 28a-f show tified at once.  Director	10	e. Street and Number		10f. Zip Code		10	g. Citizen of What Co	untry?
th the M 23a or 2 notified al Dire		525 FRANK'S LANE	- 142 W	21502 Vas Decedent of Hi		pecify Yes or No-	USA 14. Race - Ame	erican Indian, Black,
r items 23 nust be no uneral	1 1	Never Married 2 X Married 12. Was Decedent 1 Armed Forces?	If	Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	White, etc.	
F 1 1 1 1 1		Widowed 4 Divorced If Yes, Give Year		Yes 2 X No				HITE
natural xamine		15. Decedent's Education (Specify only highest grade com	during	ent's Usual Occupa most of working life	ation (Give kind of e. DO NOT use ret	work done ired)	16b. Kind of Busines	s/Industry
in 72 h		Elementary/Secondary (0-12) College (1-4 or 5	1	HOMEMAKE	R		OWN HOME	Ξ
be filed within 72 hour ntal Hygiene. rked other than "natu ent, the Medical Exar Be Completed	1	7. Father's Name (First, Middle, Last)			18.Mother's Nam	e (First, Middle, M		
uld be filed within 72 hours al Mental Hygiene. marked other than "natural c event, the Medical Examin To Be Completed by	3	DONALD R. TWIGG				TAFFORD	har City or Town Str	ate Zin Code)
e de si i	· 1	9a. Informant's Name/Relationship (Type, Print )		ing Address (Stre RANK'S LA			ber, City or Town, Sta	ate, zip code)
s I and 2 s of Health a If item 27 rer traum	2	RAY SWICK, JR./HUSBAND  0a. Method of Disposition	20b. Place of Disp	osition (Name of c		Date	20c. Location - City	or Town, State
Pages I lent of II int: If i	1	X Burial 2 Cremation 3 Removal from Sta		CEMETERY	10-	-5-2009	OLDTOWN,	MD
permit. Pages l a Department of He Important: If ite injury or other ti	2	Donation 5 Other Specify:  1. Signature of Funeral Service Ocensee	22	2. Name and Addre	ss of Facility SC	ARPELLI	FUNERAL HO	OME, PA
Der Inju	$\perp$	3a. Part V.Enter the disease, or complications that caused	1 1	108 VIRGI	NIA AVE.	CUMBERI	AND, MD 21	502 Approximate Int
hysician Medical	2	failure. List only only cause on each line.				or respiratory and		Between Onset Death
xaminer		mmed te Carre (Final disease a. Alcohol a procession resulting in death)  Due to (or as a const		one intox	cication			
	١,	Sequentially list conditions, b						
iner	<u> </u>	fany, leading to immediate						
ted Insit Examine	<u> </u>	Disease or injury that initiated events resulting in death) Last Due to (or as a consi	equence of):					
n and 1 - tran	<u>-</u>	XUNPENDED d. AMENDED 238	a,27,28a-f,	perME, g	<del>3897 11/3</del>	/09 TT	<del>_</del>	
cate be execut physician and he burial - tra	ᇍ	F FEMALE: 23c. If yes, outcome	me of pregnancy				23d. Date of deli	•
ertifica ding pl e as th	2	3b. Was decedent pregnant in the past 12 months?	t time of death 5		3 Ectopic preg	nancy	Month	Day Year
the death certification by the attending inched for use as t	385	1 Yes 2 No 9 Unknown 9 Unknown	t time of death 5	Other (Specify)				
at the c		Part II. Other significant conditions contributing to deal	th but not resulting in th	he underlying caus	e given in Part I.			e to the cause of deat Probably 4 🗹 Unkn
irres that a signed d be deta						24a. Was		e autopsy findings av
The law requires ficate has been signage 2 should be	Bet					auto	psy prior deat	to completion of caus th?
The la	팋			00.5	ace of Death (Che	Dr	2 No 1 🗸	Yes 2 1
ician: s certif rector,	e R	25. Was case referred to medical examiner? Hospital: 1 Input	ient 2 ✓ ER/Outpati		Othorn	sing Home 5	Residence 6	Other:
Phys Rer thi	<u> </u>	1 ✓ Yes 2 No 27. Manner of Death 28a. Date of Inj (Month, Day,	jury 28b. Time	of Injury 28c. I	njury at Work?	1	how injury occurred	
Attending death.  ector: All by the fur	틸	Natural 5 Pending Fd 9/30	0/09 Fd 12	2:40 pm	Yes 2 XNo	unk		
1 1 1 1 1 1 V	≌	28e. Place of i	Injury - At home, farm, s esidence	street, factory, office	ce building, etc.	28f. Location or Town,	(Street and Number of State) 525 Fr	or Rural Route Numbe anks Lane
or A after of Direct in by	- 1	4 Homicide determined (Specify) T  2ga. Certifier 1 Certifying Physician: To the best of r		occurred at the time	a, date and place a			
aspital or Attending hours after death, neural Director: After y filled in by the fune			iny knowledge, death o	occurred at the time	nion doubt accurre	d at the time, dat	e and place, and due	to the cause(s)
the Hospital or At hin 24 hours after d the Funeral Direc upletely filled in by		one) 2 Medical Examiner: On the basis of ex	amination and/or invest	stigation, in my opir	non, death occurre		O dillo pioces, elle	
	dical	Chook day	amination and/or invest		ense number		29d. Date signed	(Month, Day, Year)
To the Hospital or A within 24 hours after (To the Funeral Direc completely filled in by		one) 2 Medical Examiner:On the basis of example and manner stated	amination and/or invest	29c. Lic	ense number	OME		(Month, Day, Year)
To the Hospital or A within 24 hours after to the Funeral Direc completely filled in by	Medical	one) 2 Medical Examiner: On the basis of exand manner stated 29b. Signature and title of certifier  30. Name and address of person who completed cause of	amination and/or invest	29c. Lic	ense number	CME	29d. Date signed October 1, 20	(Month, Day, Year)

ORIGINAL,

DHMH 17 Rev 1/2001

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of Terson who comp

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2009

GAFFAR

29d. Date signed (Month, Day, Year)

ESTMINSTER, MUD 2-1151

and manner stated

ed cause of death (Item 23a) (Type, Print)

33. Registrar's Signature

	1	For Stete Registrar	State of Ma	ryland / Depa <i>Ce</i> a	artment of H			ene g. No ()	09	32204
		Decedent's Name (First, Middle, Last	1)				2. Date of Death Month	Day	Year	3. Time of Death
Physicia		BERLIN H	HILLERY	WILHELM			September		2009	2:25 a M
/Medica Examine		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c. County		
LXAIIIIII		Dennett Road M	Manor Nur	sing Hom	e Oakla			Garr		
Funeral Director		5. Social Security Number 6. Sec. 233 – 62 – 7897	ox 7. Age ☐M 2□F	(In yrs. last birthday) 90 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 9 / 11 / 1	Year) 919	9. Birthi Coul WV	
ems 23e or 28e-f ahow r must be rediffed at	-	Usual Residence of Decedent		10c. City, Town or Le	ocation					10d. Inside City Limits
ahow E		10a. State 10b. County  WV Prestor		Terra A						1 ☐ Yes 2 🗽 N
8e-1	었		1	Tella	10f. Zîp Code		10	g. Citizen of	What Cou	ntry?
Day 1	吉	10e. Street and Number 8868 Cranesvil	lle Rd		26764			U.S.		
18 23 Tuest	Funeral Director		12. Was Decedent E	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-			can Indian,
E a	Š	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 □ Yes 2 ☑ N				Rican, etc.)		ack, White,	
ro.	by	3 ₩idowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2, ☑ No	Specify:		Speci	ny: Wr	ite
ature cel E		15. Decedent's Ed	lucation	16a. Dece	dent's Usual Occup	ation	kina	6b. Kind of 8	Business/Ir	ndustry
other then "naturel", or ite rant, I'm Medical Examina	e e	(Specify only highest grade Elementary/Secondary (0-12)	Coilege (1-4or 5-	life.	kind of work done			Ed	lucat	ion
를록	Completed	12	6		Teacher		- (Fine 14) and 1			
od other then "naturel", or items 23e or 28e-1 show event, the Medical Exandrac must be notified at	Be (	17. Father's Name (First, Middle, Last)					ne (First, Middle, M			zilholm
is marked o	ဥ	Jesse C. Wilhe					Pearl			
item 27 is marke other treumetic		19a. Informant's Name/Relationship (7			ing Address (Street					_
n 27 ner tr		John M. Wilhe	lm/Son	8858 20b. Place of Disp	3 Cranes	ville R	d, Terr	a Alt 20c. Location	a, W	V 2676 Town, State
or othe	i	20a. Method of Disposition 1 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other plac	ce)   0 / 1	6/2009			
tent: If it jury or o		`4 Donation 5 ☐ Other (Specify	<i></i>	Terra Alta			0/2005	Telle	a AI	ca, wv
importent: any injury once.		21. Signature of Funeral Service Licen	X		2. Name and Addre		t Funer	al Ho	ome	0.754
E = 0		Mark L.	per		Tos High	land Av	e, Terr	a AIt	a, W	V 26764 Approximate
		23a. Part1. Enter the disease, or conshock, or heart failure. List only	plications that caused one cause on each lin	the death. Do not er	the mode of dyli	ng, such as cardia	or respiratory arre	2 /		Interval Between Onsera d Death
sician edical		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a	a conse uence of):	c fi	OTTA	re C	17		192
aminer	<u>-</u>	Sequentially list conditions,	b. Due to (or as a	a consequence of):	-				-	
insit	Examiner	Sequentially list conditions, it is a sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events								
sician and burial-transit	Exa	resulting in death) Last	Due to (or as	a consequence of):						
sicia e bur	cal		d						-	
g phy as th										-
ed by the attending physi detached for use as the I	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth	of pregnancy 2  Fetal death 3	□Ectopic pregnanc	y			Date of deli Month	ivery Day Year
e att	sicla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at 9☐Unknown		Other (specify)					,
by th	hys	9 Unknown				is Book	22a Did to	hacco use co	ontribute to	the cause of death?
s been signed to should be det	ρ	Part II. Other significant conditions of	contributing to death b	ut not resulting in the	underlying cause gr	ven in Part I.		es 2 No		
shor	Completed						24a. Was a	in 241	b. Were au	topsy findings availa
2 0	Ē						autops perfor	med? 2 No	death?	2□ No
fficate or, pa	ပို	25. Was case referred to medical				26. Place of De	ath (Check only or			
certi	00	examiner?  1 Yes 2 No	Hospital:	ent 2 ER/Outpati	ent 3 DOA Ot		Home 5 Resid		Other (Spe	cify)
fter this neral di	on; To	27. Manner eath 1 tural 5 □ Pending	28a. Date of Inju (Month, Da	ry 28b. Time	of 28c. Inju	iry at ork?	28d. Describe h			
within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page	Certification;	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Inj	ury - At home, farm, c. (Specify)		]Yes 2□No	28f. Location (S City or Tow	itreet and Nu n, State)	mber or R	ural Route Number,
I Dir	Sert									
Funere stely fille	edicai (	29a. Certifier 1 Certifying Property (Check only one) 2 Medical Exa	hysician: To the best miner: On the basis o and manner st	f examination and/or	ath occurred at the tinvestigation, in my	ime, date and plac opinion, death occ	e, and due to the durred at the time, o	ause(s) and date and plac	manner as e, and due	s stated. e to the cause(s)
thin o the mple	Mec	29b. Signature and title of certifier			29c. Licer	ise number		29d. Date sig	ned (Mont	th, Day, Year)
8 ∺ 8		1/1/1/1/1/1/	TOST	rdan	N4	1464		9/1	7/20	009
	8	30. Name and address of person who	complete cause of cooperations	death (Item 23a) (Typ	29c. Licer D 4 e, Print)	tel, Da	Kland	MO S	215	50
Sta	ate	31. Date filed (Month, Day, Year)		rar's Signature			<u> </u>			
Regist		CED 172	nng	B d	Bertha					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day September 18, 2009 **Physician** 9:23pm M Clara Lee Wiedecker /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Towson Gilchrist Hospice Center If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Jan 19, 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Country) NM Months 1 □ M 2 □ F 59 220-50-0991 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State 7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examinat runst be notified at 1 ☐ Yes 2 N No Sykesville Director MD Carrol1 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 USA 1333 Hillcrest Drive Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ If Yes, Give A Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Analysis Company Service Writer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Juanita Short Raymond Vigil ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau 1333 Hillcrest Drive Sykesville, MD 21784 Mr. Brian Wiedecker (Spouse) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State All County Cremation 9/20/2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License <sup>22</sup> HAIGHT FUNERAL HOME & CHAPEL, P.A. MO0764 PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each live. Approximate Interval Between Onset and Death Immediate Cause (Final Physician a disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Else to Joseph Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 MNo Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached Ö 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tohacco use contribute to the cause of death? Records, 1 ☐ Yes 2 № No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 X Ho 1 ☐ Yes 2 ☐ No Vital 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2∭2No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ð After this 27. Manner of eath 1 Natural 2 Accident 28b. Time of Injury ne Hospital or Attending Pl n 24 hours after death. ne Funeral Director: After th 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 X certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. To the ! within 2

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 200 9 **Physician** NIAE 10 /Medical 4b. City, Town, or Location of Death 4c. County of Death. acility Name (If not institution, give street and number) Examiner CENTUR VICOMICO If Under 1 Year Date of Birth (Month, Day, Year) 3-15-1932 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Months Days 1 □ M 2 🔀 F MARYLAND Director 220-26-9000 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 200. 1 any Injury or other traumatic more. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1⊠Yes 2□No SALISBURY Director Wicomico ARYAND 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number SENNOR 21801 U.5A) by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 25 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 BNo Specify: Black 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Dietitian 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ORDIN SANGL YACKSON 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) OWENDOWN A 15 DURY 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home EUAR Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hard failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) MUNIO 17445 **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi Due to (or as a consequence of) P.O. Box 68760 physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No After this certificate 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attend within 24 hours after death To the Funeral Director: 2 Accident filled in by the 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

State Registrar

Medical

29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Year)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Vear **Physician** ROBERT SEPTEMBER 28, 2009 WILSON 2:20 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FOREST HILL HEALTH & REHAB CENTER HARFORD FOREST HILL . Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/26/1931 9. Birthplace (State or Foreign **Funeral** Months Days Hours 1 □**X**M 2 □ F 162-26-2710 77 Pennsylvania Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once. York PA Delta 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 993 Pikes Peak Road 17314 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No1 9 5 2 − IYes, Give Year or Dates: 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Manufacturing/ Elementary/Secondary (0-12) College (1-4or 5+) Repair Metal Worker/Welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John B. Wilson Lillian Thompson ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David J. Wilson/Son 47 Gable Hill Road, Wrightsville, PA 17368 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Nebo Cemetery 10/2/2009 Delta, PA 21. Signature of Funeral Service Likensee 22. Name and Address of Facility Harkins Funeral Home, Inc., Delta, PA 23a. Part 1. Enter the disease, or or polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician chrone obstruction disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, sate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 2 No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1☐Yes 2☐No Other: 4N Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i or Attending P after death. I Director: After d in by the funera Natural Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled it 29a, Certifier 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 03222 Septimber Ly 2009

Registrar
DHMH 17 Rev 1/2001

DIS

State

DAVID DUNN

31. Date filed (Month, Day, Year)

BEL AIR, MD.

21014

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MACPHAIL ROAD

32. Registrar's Signature

615 W.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month O **Physician** 650 M MARTHA FRANCES WINEBRENNER /Medical ounty of Death 4b. City, Town, or Location of Death Examiner llegan WIts lampus Cumberlang raddock 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Months Days 09-14-1919 1 □ M 2 KF MARYTAND 90 218-16-3866 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov 1 Yes 2 No Director MD ALLEGANY FROSTBURG 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ir than "natural", or items 23a or 21532 81 E. MECHANIC ST. APT B6 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married 0 Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: WHITE δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOUSEKEEPING CELANESE ulth and Mental Hygid

27 Is marked other retraumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be HENRY WINEBRENNER <u>ANNIE (PLUMMER) WINEBRENNER</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Department of Health a Important: If item 27 is any Injury or other trau once. GRANDDAUGHTER 68 LAVALE BLVD LAVALE, MD 21502 KIMBERLY BOOTH 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State f Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) RESTLAWN MEM GARDENS 10-05-2009 CUMBERLAND, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility SOWERS FUNERAL HOME, FROSTBURG, MD 21532 Han 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mole of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on the heart failure. FROSTBURG, MD Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** cresh /Medical Due to (or as a contequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed signed by the attending physician and be detached for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 PERTENSION 2 No 1 ☐ Yes 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should I Completed 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? ATRIA Promilano Division of Vital 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation ours after death.

neral Director: A
filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital o within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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Cimberary M

30 2009

OBER

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

			State of Maryland / Department of Health and N 1- State Amend Item 5 per F.D. 09/28/2009 Carroll Cont will Registrar	Mental Hyg	giene Reg. No.2 () () (	32209
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	ith Day Yea	
	/Medic	al	WAYNE L YINGER  4a. Facility Name (If not institution, give street and number).  4b. City, Town, or Location of Death	9	4c. County of De	
	Examin	er	UNIVERSITY of MARYLAND MEDICAL CENTER BALTIMORE			
	Funeral Director	-	2 15 46 7689 6. Sex 1	8. Date of Birth (Month, Day July 29	9. E 1943	Birthplace (State or Foreign Country)  MD
-			Usual Residence of Decedent  10a, State 10b, County 10c, City, Town or Location			10d. Inside City Limits
	Maryla Istan	tor	MD Carroll Finksburg			1 ☐ Yes 2 🛣 No
	or 28a	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What	Country?
1	ns 23a	Funeral	4600 Sykesville Road 21048  11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1062 13. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerts			merican Indian,
36	be filed within 72 hours after death with the Maryland tat Hygiene. tat Hygiene. do other than "natural", or items 23a or 28a-f show event, It a Medical Ers nit or must be notified at	by Fur	1 □ Never Married 2 ▲ Married 1 ▼Yes 2 □ No 1902 − 1 □ Yes 2 ▼No Specify:	o Rican, etc.)	Black, W	
215-0036	2 hour latural' leal Ex	ted b	15. Decedent's Education 16a. Decedent's Usual Occupation	(i==	16b. Kind of Busine	
121	vithin 7 ane. than "n	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)  College (1-4or 5+)		construct	tion
מ מ	al Hygie other 1	a	17. Father's Name (First, Middle, Last)  18. Mother's Name	ne (First, Middle,	Maiden Surname)	
Maryland 2	should be to and Mental marked o umatic eve	To B		. Edmond		
	es 1 and 2 should by the alth and Ment of Health and Ment fitem 27 is marked rother traumatic e		19a. Informant's Name/Relationship (Type. Print)  Mrs. Sharon Yinger (spouse)  19b. Mailing Address (Street and Number or Ru 4600 Sykesville Rd.,			
<u>e</u>	Pages 1 a nent of Hea nt: If item iry or othe		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City	
֓֞֟֝֟֝֟֝֟֝֟֝֟֝ <u>֚</u>	permit. Page Department of Important: If any Injury or once.		4 □ Donation 5 □ Other (Specify) Providence Cemetery 9-22-  21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ha:		Finksburg	
	Dep Imp		Paguajaight aferbert P.O. Box 195 Sykes			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	or respiratory ar	rrest,	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):			
E	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate  b. Perticular Conditions, Due to (or as a consequence of):			WEEK
	d ansit	Examiner	if any, leading to immediate cause. Enter Uniderlying Cause (Disease or injury that initiated events c.			
Č,	ceruircate be executed ding physician and se as the burial-transit					
09/89	g physi	edical	d.			
X POX	death certific	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of Month	delivery Day Year
. 1	ed by the a	nysic	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			
S	w requires that the or is been signed by the should be detached	δ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			to the cause of death?
ecord	w requires been sign should be	leted	CORONARY ARTERY DISEASE	24a. Was	/es 2 No 3 □	Probably 4 Tonknown autopsy findings available
ב ו	s certificate has birector, page 2 sl	Completed	CORONARY MRTERY VISEASE	autop	rmed? prior death	to completion of cause of
VITAL	r this certificate har director, page	Be	examiner?	th (Check only o		
5	ral di	<u>:</u>	1 Prinpatient 2 EH/Outpatient 3 DOA 4 Nursing H		dence 6 Other (S	pecify)
SION	Attending Prince of the death.  ector: After the by the funeral	ation	1 ☑ Natural 5 □ Pending (Month, Day, Year) Injury Work? 2 □ Accident investigation M 1 □ Yes 2 ☑ No		,,	
	or Aug after de Director in by ti	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tox	Street and Number or vn, State)	Rural Route Number,
-	io the nospital of Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu		29a. Certifier  (Check only  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occur			
1	thin 24 the Flormplete	Medical	one) and manner stated.		29d. Date signed (Me	
<b>,</b>	2 3 4 8		18938 18938	23457	9/17/	2009
1	PTX		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Baltim	am MD	21201
	Sta	te	31. Date filed (Month, Day, Year) SEP 22 2009 SEP 22 2009 SEP 22 2009 SEP 22 2009	Carrim	OF MO	
	Registra	ar	SEP 2 2 2009 Somme B. Sparker			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Doris M. Peterson Ault October 5 2009 2:40 A. Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Baltimore Gilchrist Hospice Towson 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year, Nov. 12. 5. Social Security Number If Under 1 Year If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** 1 □ M 23€34 Hours Min Director 213-20-3402 1924 Nov. Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Maryland N/A Baltimore 1 X Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? 4444 LaPlata Avenue Funeral 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i Completed by 1 Never Married 2 Married 1 Yes 2 XNo Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: Specify 3X Widowed 4 ☐ Divorced Year or Dates Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) David Milburn Dailey Dora Masemore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 247 Highmeadow Road Reisterstown, MD 21136 19a. Informant's Name/Relationship (Type, Print) Jean Saez Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State any Injury or 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Pine Grove Cemetery 10/09/2009 4 Donaton 5 Other (Specify) Rayville, Maryland 21. Signature Funeral Service Licansee <sup>22. Name and Address of Facility</sup> Burgee-Henss-Seitz Funeral Home, Inc. 21211 Falls Road, Baltimore, Maryland 23a. Part 1. Exper the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Utorus Physician/ ances O disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or iinjury Examine Due to (or as a consequence of) sician and bunial-transit that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IE EEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) Pregnant at time of death 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Records, 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 Yes of Vital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 N Other (Specify) 1 Yes ျှ 1 Inpatient 2 I ER/Outpatient 3 DOA funeral Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division 1 Yes 2 No Investigation Accident within 24 hours after death

To the Funeral Director; A

completed filled in by the f 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HANCES MO

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🗸 🖰 Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Octobe lehhoob 2009 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Baltimore City** The Johns Hopkins Hospital 9. Birthplace (State or Foreign Countingia) 8. Date of Birth Feb. 24, 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Year 943 Days 1 XM 2 □ F 66 Months Hours 156-44-8808 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1X Yes 2 No Arlington Arlington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code United States 22207 712 A. West Glebe Road 12. Was Decedent Ever in U.S Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Asian-Indian Specify 3 XWidowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Surgeon Medicine 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shaiah Imamuddin Naviran Bi Ahmed 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 55 Caldwell Road, Edison, New Jersey 08817 Mubarak Ahmed, Son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Jersey State Memorial Park 10/09/2009 20c. Location - City or Town, State 20a. Method of Disposition 1X Burlal 2 ☐ Cremation 3 ☐ Removal from State Millstone Twp., NJ 4 Donation 5 A Other (Specify) 22. Name and Address of Facility M.J. Murphy Funeral Home 21. Signature of Funery Service Licensee T. Harman W P.O. Box 34, Monmouth Junction, NJ 08852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final coronary Artery PISECISE disease or condition resulting in death) Due to (or as a consequence of) Prortic Stenosus severe Sequentially list conditions, Qualify (Science assessment), off cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No Yes 2 No 1 Tyes 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4  $\square$  Nursing Home 5  $\square$  Residence 6  $\square$  Other (Specify) 2 X No 2 🗌 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No

or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760 s after death.

the burial-trai use as detached f been signed b should be det funeral director, After this filled in by within 24 hours a

Physician /Medical

Examiner

**Funeral** 

Director

or 28a-f show notified at

ō death with

ral", or items 23a or Examiner must be

and 2 should be filed within 72 hours after tealth and Mental Hygiene.
m 27 is marked other than "natural", or ite ner traumatic event, the Medical Examiner.

Important: If item 27 is any injury or other traunonce.

**Physician** 

/Medical

Examiner

Pages 1 ment of H

altimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

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Examiner

Physician/Medical

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Completed

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Certification:

Medical

29a. Certifier

VA

25. Was case referred to medical examiner? 1 🗌 Yes 27. Manner of Death

1X Natural 2 Accident 6 Could not be determined 3 Suicide 4 - Homicide

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

(Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(check only one) 29b. Signature and title of certifier

es-000

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

- IMD

Roshni I. Thakore 600 North Wolfe St, Baltimore, MD, 21287

State Registrar 31. Date filed (Month, Day, Year)



R. THAKORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17&19 tate of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER Day 2009 1:35 A M **EVELYN** ROSE **ARBESMAN** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GILCHRIST HOSPICE CARE TOWSON 8. Date of Birth Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min. 1 □ M 2 🕱 F Months Hours 04-14-1932 0K 556-38-6946 77 **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 🌠 No MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? the Street and Number Funeral 3203 OLD POST DRIVE, APARTMENT #1 USA 21208 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: Completed 3 Widowed 4 Divorced WHITE Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER OWN HOME Be 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) 2 ABRAHAM BRODSKY RUTH FRIEDMAN Borofsky 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) BERNARD ARBESMAN/HUSBAND 3203 OLD POST DRIVE, #1, BALTIMORE, MD 212<u>08</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10/0672009 1<del>0-09-2009</del> BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) RUDOMER VEREIN 22. Name and Address of Facility SOL LEVINSON & BROTHERS. 21. Signature of Funeral Service Licenses 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. nset and Death Immediate Cause (Final ancer Physician disease or condition Medical resulting in death) Due to (or as a \* nsequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last the burial-tran attending physician and Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 - Ectopic pregnancy in the past 12 months?

1 Yes 2 WNo
9 Unknown Month Year Day 5 Other (specify) Pregnant at time of death 4 ☐ Pregnant : g ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Hunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy After this certificate has performe death? 1 🗆 Yes 2 🗴 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 🗌 Yes 4 Nursing Home 5 Residence 6 NO Other (Specify) NW S D ( 4 မှ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Natural 1 ☐ Yes 2 ☐ No Accident Investigation 2 Accident
3 Suicide
4 Homicide within 24 hours after deat To the Funeral Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by determined Hospital Medical stated. Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29b. Signat 8303 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N-Charle

Registrar

DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 2009 5:43 A M Charlotte October Marv Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Center Towson 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs, last birthday **Funeral** Hours July 20, 1927 1 □ M 2 🕅 F 82 Mary Land 219-20**-**9620 Director Usual Residence of Decedent 10d Inside City Limits 10b, County 10c. City, Town or Location "natural", or items 23a or 28a-f sho 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🌠 No Maryland Frederick Mount Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21771 USA 1111 Leafy Hollow Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian, 11. Marital Status Black White etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 🗐 No 3 X Widowed 4 □ Divorced Year or Dates 27 is marked other than "natu traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other than Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Frederick Christopher Frederick Mary Helen Murley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2. Department of Health and Important: If item 27 is a linium or other trains 1111 Leafy Hollow Circle Mount Airy, Maryland 21771 Son Robert Lee Barker, Sr., 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Metro Crematory Inc. 10/07/09 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licenses Thomas Gregor 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Dementis years Physician/ PICATIONS disease or condition resulting in death) Medical Due to (or a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 XNo Month Year Day Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 TYes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ after death. Director: After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🔼 Natural 1 🗌 Yes 2 🗌 No Accident Suicide Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Direc Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) and title of certifier 29d. Date signed (Month, Day, Year) 29b. Signatur 2009 address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 2. Registrar's Signature

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MARLES

CHARLES

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31. Date filed (Month, Day, OCT 0

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		1 - State of N Registrar		artment of Health and I Stificate of Death	Mental Hygie Reg.	/ 11 1 7	32214	
		Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Year	3. Time of Death	
Physic /Med		William Douglas Baylo	or	4b. City, Town, or Location of Death	October	06 09	9:57 AM	
Exami	iner	4a. Facility Name (If not institution, give street and number	4c. County of Deal	th				
<i>(</i>		Union Memorial Hospita  5. Social Security Number 6. Sex 7.	私 Age (In yrs. last birthday)	Baltimore If Under 1 Year   If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign	
Funeral Director		219-26-8698 *** 2 F	70 Yrs.	Months Days Hours Min.	Sept 2		Maryland	
7		Usual Residence of Decedent			sept. z	27 1933	10d. Inside City Limits	
arylar show	7	10a. State 10b. County N/A	10c. City, Town or Lo	imore			1√2 Yes 2 □ No	
he Ma 28a-f	ecto	Maryland 11/ A	Dune	10f. Zip Code	100.	Citizen of What Co		
with t	ij	5000 Denview Way Apt.	G	21206		USA		
16. Will y latter 2.12.15.0000  1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.  1 Health and Mental Hygiene.  1 Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "natural" or items 23a or 28a-f show other traumatic event, the "natural" or items 23a or 28a-f show	/ Funeral Director	11. Marital Status  1 Never Married  1 Never Married	nt Ever in U.S. 13. \ s? ☐	Nas Decedent of Hispanic Origin? (S f Yes, specify Cuban, Mexican, Puert t □ Yes 🏖 No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit		
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al Hyg	Be C	17. Father's Name (First, Middle, Last)			ne (First, Middle, Mai V. Garl			
should be and Mental a	2	William R. Baylor					24.226	
2 sho h and ls ma		19a. Informant's Name/Relationship (Type. Print) Deborah Lawson Baylor		ng Address (Street and Number or Ri Denview Way A	ral Route Number, C	ity or Town, State, timore.	<i>Zip Code)</i> 21206 Maryland	
s 1 and 2 of Health item 27		20a. Method of Disposition	20b. Place of Dispo	sition (Name of		c. Location - City or		
permit. Pages Department of Important: If its any Injury or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from Sta 4 ☐ Donation 5 ☐ Other (Specify)	te Mt. Zio	on Cemetery 10			,Maryland	
Departing Department of the properties of the pr		21. Signature of Funeral Service Licensee		2. Name and Address of Facility 2.40 Reistersto			uneral Hom	
		23a. Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each	sed the death. Do not ent				Approximate Interval Between	
Physician		Immediate Course /Final		Emboli, Resp	iration F	nilure	Onset and Death	
/Medical	1	resulting in death)  a. Due to (or as a consequence of):						
Examine		Sequentially list conditions b. Dee		Thrombosis			2 days	
, 6 /	ine	cause. Enter Underlying	as e consequence of):	0.0	11.		1 140.00	
and and li-tran	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or	state Can as a consequence of):	cer sip che	m o + nera	Pg	1 year	
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tificate g phy as the		u.						
To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending it completely filled in by the funeral director, page 2 should be detached for use as	Physician/M		th 2 ☐ Fetal death 3 ☐ nt at time of death 5 ☐	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	elivery Day Year	
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equire en sig					1 ☐ Yes	2 □ No 3 🖼 1	robably 4 🗆 Unknown	
The law requires that has been signed age 2 should be contact.	Completed	A			24a. Was an autopsy performe 1 □ Yes 2 □	prior to death?	autopsy findings available completion of cause of	
VILCI Iclan: 1 certifica ector, p	Be	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)			
Physic rthis corral dire	2	1 Yes 2 No Hospital: 1 1 Infine	atient 2 ER/Outpatie		Home 5 Residen		ecify)	
ing P	, i	1 Landidata 0 Lincolding	Injury 28b. Time o Day, Year) Injury	Work?	28d. Describe how	injury occurred		
SIO teath. tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be 28e Place of	Injury - At home, farm, st	M 1 Yes 2 No	28f Location (Stre	et and Number or F	Rural Route Number,	
LIVISION  lor Attending after death.  Director: After din by the fune	Certification:		, etc. (Specify)	eet, lactory, office	City or Town,	State)	rara riodio rvanibor,	
Hospital 24 hours : Funeral stely filled	Medical Ce	29a. Certifier (Check only one)  29a. Certifying Physician: To the base and manne	is of examination and/or in	th occurred at the time, date and place nvestigation, in my opinion, death occ	e, and due to the cau urred at the time, dat	use(s) and manner e and place, and du	as stated. ue to the cause(s)	
o the vithin o the comple	Mec	29b. Signature and title of certifier		29c. License number		I. Date signed (Mor		
F S F O		> El 1	- MD	AT-8 2433	146	010610	9	
2		30. Name and address of person who completed cause  Elena Foronhar, Uni	of death (Item 23a) (Type,					
s	tate	31. Date filed (Mortin, Day, Tear)	istrar's Signature	,		-	21218	
Regis	trar	OCT 08 2009 General	B. A GRAN					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible and #17 ner Fh 2896 10/13/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Brooks Joseph Leo Medical 2009 40a 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5200 Bowleys Lane Apt 211 Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗶 M 2 🗆 Months Days Hours Min. (Month, Day, Year) Countr **Director** 214-22-2074 82 OH Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No NA Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21206 5200 Bowleys Lane Apt 211 death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, "natural", or iter edical Examiner Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 TNo Specify: Black Specify: 3 X Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 72 (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nould be filed within 72 nd Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Delivery Assistant State of Maryland 6th grade injury or other traumatic event, Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If Item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sadie Brooks Dan <del>Epps</del> Espy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Md 21219 Baltimore, 3518 West Garrison Ave, <u> Gloria Davis-Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Page 1 ? 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland National 10/10/09 Other (Specify) Laurel, MD Sk 22. Name and Address of Facility
March F/H West 21. Funeral Service Licensee 300 Wabash Ave. Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Waldenstroms macrolobinemia Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Directo (or as a consequence of): Exami The law requires that the death certificate be executed g physician and is the burial-trans Due to (or as a consequence of): Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Pregnant at time of death signed by the a 2 No g Unknown 9 Unknown P.O. Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, cate has been signated bage 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? After this certificate 1 Yes 2 No Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 2 1410 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death

To the Funeral Director: ocmpleted filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie MD AU4176435W17470

DHMH 17 Rev 7/2009

State

Registrar

balt, more

21230

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

rindall

. Registrar's Sign

Weld

31. Date filed (Month, Day, Year)

			for State Registrar	State of	Marylan		artment of H		nd Mental H	lygiene Reg. No.	200	9 32215	
	1. Decedent's Name (First, Middle, Last)						2. Date of	Death		3. Time of Death			
п	Physici		Lillian Boduky						Month Octob	Day er 0		NA NA	
· Wall	/Medi Examir		4a. Facility Name (If not institution,		nber)		4b. City, Town, or	Location of			County of De		
	LXuiiii		Glen Burnie Hea	lth & Reh	ab		Gle	n Burr	nie		Anne A	rundel	
	Funeral		Social Security Number 6		7. Age (In yrs. i	last birthday)	If Under 1 Year	If Under 2	4 Hrs.   8. Date of	Birth Day, Year)	9. E	Sirthplace (State or Foreign Country)	
	Director		073-32-5485	1 □ M 2 🔀 F	9	5 Yrs.	Months Days	Hours	Min. (Month,	12 19		NY	
	P ,		Usual Residence of Decedent										
	arylaı show	_	10a. State 10b. County		10c. City	y, Town or Lo	cation					10d. Inside City Limits	
	8a-f	cto		Arundel			Gle	n Burr	nie			1 □Yes 2 ☑No	
	or 2	Dir	10e. Street and Number				10f. Zip Code			10g. Citi	zen of What	Country?	
	ath w	<u>ra</u>	7355 Furnace Br					2106			USA		
	er de	nue	11. Marital Status	Armed For		S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Orig ın, Mexican,	in? (Specify Yes or Puerto Rican, etc.)	No-	<ol> <li>Race - Ar Black, Wh</li> </ol>	nerican Indian, nite, etc.	
36	s afte	×	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Giv	е		1 □Yes 2 및 No	Specify:			Specify:	White	
21215-0036	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Exemits at must be notified at	Completed by Funeral Director		Year or Da	ites:	16a Doco	dent's Usual Occup	ation		16h Kir	nd of Busines		
15	n 72 i "na	let	15. Decedent's (Specify only highest	grade completed)		(Give	kind of work done of DO NOT use retired	during most (	of working	160. Kii	nd or busines	ss/mausiry	
12	withi ene. thar	E E	Elementary/Secondary (0-12)	College (1-	4or 5+)	<i></i>	Homem	,			House	hold	
0	filed Hyg other ent, I		17. Father's Name (First, Middle, La	st)		<u> </u>	nomem		's Name (First, Mid	dle, Maiden		.11010	
an	d be ental ced c	o Be	Ţ	Jnknown					Unl	cnown			
Maryland	shoul nd M mari	မ	19a. Informant's Name/Relationship	(Type, Print)	-	19h Mailir	na Address (Street )	and Number	or Rural Route Nu		r Town State	Zin Code)	
Z	od 2 s afth al 27 Is r trau		Richard Czyz	(1)			,				*		
ē	Hea Hea tem	13	20a. Method of Disposition		20b. P	lace of Dispo	sition (Name of	i	nue, Pasac Date			or Town, State	
Baltimore,	ages ant of tt: If I		1 ☑ Burial 2 ☐ Cremation 3		itate I		natory`or other plac onds Ceme <sup>-</sup>		ct. 08	Pron	v Nov	Vorde	
≟	artme prtan prtan injur		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service மி		50.		2. Name and Addres		2009	PION	x, New	TOTK	
Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examire traust be notified at once.		21. Signature of Pulleral Service Cit	TA A	1	)   "			Stalli Road, Pa	ngs Fi	neraL	Home, P.A.	
			23a. Pa 1. Enter the disease, or o	molications that ca	used the leath	Do not ent					a, MD 2	Approximate	
			shock, or heart failure. List or	ly one cause on ea	ich lin	i. Do not em	er the mode of dyni	g, such as c	ardiac of respirator	y arrest,		Interval Between Onset and Death	
- Car	Physician /Medical		disease or condition resulting in death)	_a. /tsp/	retion	PNU	money						
41	Examiner	0	1	Dyfe to (d	or as a consequ	uence of):							
		<u>.</u>	Sequentially list conditions,	b. Due to /	or as a consequ	iongo of						_	
	ted nsit	Ē	if any, leading to immediate cause. Enter Underlying Cuse (Usease of jury) that initiated events	Due to (t	n as a consequ	ience on.						,	
	cate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c	or as a consequ	uence of);							
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387	ficate phys s the	dical		d									
9 X	certif ding se at	N.	IF FEMALE: 23b. Was decodent program: 23c. If yes, outcome of pregnancy							204 Data of define			
in the past 12 months?					☐ Live birth 2☐ Fetal death 3☐ Ectopic pregnancy☐ Pregnant at time of death 5☐ Other (specify)☐					23d. Date of de Month		Day Year	
P.O.	the d	ysi	1 ☐ Yes 2 No 9 ☐ Unknown 9 ☐ Unknown										
σ.	that the de ned by the detached		Part II. Other significant conditions	contributing to dea	ath but not resu	ılting in the u	nderlying cause give	en in Part I.	23e. D	id tobacco u	se contribute	to the cause of death?	
Records,	signed d be det	Completed by	Doma Tu Husen timber						1	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown			
ò	w requir s been s should I	ete	Denver , Type war wen					_		1			
3e	e law has je 2 s	ם		/					24a. W	as an utopsy erformed?	24b. Were prior t death	autopsy findings available o completion of cause of	
a	r: Th icate r, pag								1 □ Ye		1 🗆 Y	es 2 🗆 No	
Vital	sician: The certificate h rector, page	Be	25. Was case referred to medical examiner?	Hoenital:			Otho	26. Place of Death (Check of		only one)			
of	Phys this al dii	은								Home 5 ☐ Residence 6 ☐ Other (Specify)			
'n	ffel ne	<u>io</u>	27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 2 ☐ Accident investigation 28a. Date of Injury 28b. Time of Injury Work? 1 ☐ Yes 2 ☐ No							28d. Describe how injury occurred			
Sic	Attendi death. ctor: A y the fu	cat	2 Accident investigat 3 Suicide 6 Could not	6.4	f ladama AAA			Yes 2∐N					
The part of the pa						n (Street and Town, State,	eet and Number or Rural Route Number, State)						
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	Hos 24 hc Fun tely	lica	(Check only 2 Medical Ex	aminer: On the ba	sis of examinat	tion and/or in	vestigation, in my o	ne, date and pinion, death	n place, and due to h occurred at the tir	me cause(s) ne, date and	) and manner I place, and d	ue to the cause(s)	
	ithin ;	Medical	29b. Signature and title of certifier	and mann	ei stateu.		29c. License	numher		29d Dat	e signed (Mo	nth, Day, Year)	
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	n 1			111			1 4 58	758		10/3	109		
	カソ		30. Name and address of person wh	o completed cause	of death (Item	23a) (Type,	Print)	11.	0,0	00	1	nie MD2186	
	- 24	to.	31. Date filed (Month, Day, Year)	32. Re	gistrar's Signat	A & C	run Ily	YhWI	y JW	Ulin	114	ING INGOLIA	
	Sta	TG.	00000	LE UZ. TIC	July	F	,	1	/				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 12:21 AM 2009 - BALLARD 0 ECI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner butimore VA Medica
5. Social Security Number 6. Sex Baltimove If Under 1 Year | If Und N/A Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** 1 ☑ M 2 ☐ F Months Days Hours 85 Yrs. 220-14-4048 Sept. 1924 TN Director 18 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 ☐ No Director Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 7871 Crilley Road 21060 23a IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Bace - American Indian. Pages 1 and 2 should be filed within 72 hours after on the file of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: ò 3 ₩ Widowed 4 Divorced White "natural". Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Secondary (0-12) College (1-4or 5+) Sales & Service Fire Equipment 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be is marked oth Marshall 2 Brown Georgianna Hick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health and Sue Kaiser (daughter) P.O. Box 1761, Pasadena, MD 21123 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 09 permit. Pages
Department of
Important: If it
any Injury or o 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Glen Haven Cemetery 2009 Glen Burnie, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 23a. Part | Enter the disease, or con, dications that cause of the di ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Septilema DAY disease or condition resulting in death) /Medical Due to br as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause End U dening Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 🗆 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>≥</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X ☐ nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X**No 1 ☐ Yes 1 TYes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 \( \sum \) Nursing Home Hospital: 1 Yes 2 No 1 Minpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral D

completely filled i 1X ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my color 29a. Certifier ical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number NF1 145 758629 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ION. GREENEST BALTIMORE, MD MD VASWANI

State Registrar

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Division of Vital Records,

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nondor Eddio B		1- For State Registrar				Death	and iv	nemai m		. No.	09 3221
Physici Medical Exami	an/	1. Decedent's Name (First, Middle,Las								Day Year	3. Time of Death 0109 hrs
neuicai Exami	Hei	Michael Loui  4a. Facility Name (if not institution, given			4	b. City, Tov	vn, or Loca	ation of Death	October 2,	4c. County of Dea	
		700 West Patapsco Aven	•			Baltimo	re			N/A	
Funeral		5. Social Security Number 6. S	ex 7. Age (In y	s. last birt	hday)	If Under		Under 24Hrs Hours Min.	_	(MM/DD/YYYY) 9. E Fore	eian
Director		2110 100	M 2 F	51	Yrs.	Wichins	Days	Toda's IVIII	12/07/	1957	Country) VA.
any		Usual Residence of Decedent  10a. State 10b. County	10c. C	City, Town	or Locatio	on					10d. Inside City Limits
<b>*</b>	'n	Md. Anne A	rundel	G1	en I	Burn	ie				1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	10e. Street and Number				10f. Zip C			10	g. Citizen of What Co	ountry?
ith the ? 23a or notiffe	i D	8051 Solley			140.00	210		0::0/0		USA	Dist.
death w or items	Funeral	<ul><li>11. Marital Status</li><li>1 Never Married 2 Married</li></ul>	12. Was Decedent Ever in Armed Forces?					xican, Puerto	pecify Yes or No- Rican, etc.)	White, etc.	erican Indian, Black,
after de	by Ft	3 Widowed 4 Divorce	1 Yes 2 X N If Yes, Give Year or Dates:	0	1	Yes 2	No sp	ecify:		Specify: B	lack
hours natur		15. Decedent's Education (Specify of	nly highest grade completed					Give kind of v		16b. Kind of Busines	s/Industry
136 hin 72 e. than "	Completed	Elementary/Secondary (0-12) 12	College (1-4 or 5+)		Coi	ntrad	ctor			rivate (	Company
5-00 led wit Lygien other lbe Me	Соп	17. Father's Name (First, Middle, Last	)					fother's Name	(First, Middle, M		
e, MD 21215-0036 I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f short traumatic event, the Medical Examiner must be notified at once	Be	Shirley Boyd			Carrie McArgo   9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
MD 2 nd 2 shoul alth and N m 27 is m	ပ္	Carolyn S. Boy								per, City or Town, Sta ${ m rnie}$ , ${ m Md}$	
e, N I and 2 Health item 2	100	20a. Method of Disposition	20	b. Place	of Disposi	tion (Name			Date	20c. Location - City	
Pages nent of ant: If or other		Burial 2 Cremation 3  Dogation 5 Other Specify			tory or oth	remat	torv	10/	9/2009	Catonsv	ille Md.
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", Injury or other traumatic event, the Medical Examiner.		21 Signature of Funeral Service Lice		2	22. N	ame and A	ddress of F	acility other:	s Funer	al Servitimore,	ice.PA
		23a. Part I. Enter the disease, or com-	lications that caused the de	atty our	at enter III	1300°	Euta	aw Pla	ace, Bal	timore, N	Md. 21217 Approximate Interval
Physician /Medical		failure. List only one cause on e	ach line. Multiple Injuries	1	100		-yg,			.,,	Between Onset and Death
√ ¬xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence	ce of):							
	ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a consequence	e of):							
	amin	cause. Enter Underlying Cause (Disease or injury that initiated									
A red ansit	Exa	events resulting in death) Last	Due to (or as a consequent	ce of):							
e execucian an	lical	UNPENDED	AMENDED								
Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p	regnancy			• □			23d. Date of deliv	· .
x 68 th certificate tending	iciar	past 12 months?	1 Live birth 4 Pregnant at time of			al death ner (Specif	L	Ectopic pregna	ancy	Month	Day Year
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ecol ne law te has ge 2 st	dmo								autops perform	n <u>ed</u> ? death'	
25. Was case referred to medical examiner?  1						103 2 10					
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risior r Attend er death rrector; o by the	ertification:	2 Accident Investigat	ion 28e Place of Injury - 4	At home, fa	arm, stree				28f. Location (S	treet and Number or	Rural Route Number, City
Div Dital or Durs aft	ie i	3 Suicide 6 Could not determine	be					-	or Town, St		
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:	calC	Condon diny	ian: To the best of my know	-							
To the within To the comp	Medical	one) 2 ✓ Medical Examine 29b. Signature and title of certifier	r: On the basis of examination and manner stated.	ni and/of I	iivestigati		License nu		at the time, date a	29d. Date signed (A	
	- 1									5 (1.	,

State 31. Date filed (Month, Day, Year)
Registrar 007 08 2009

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ORIGINAL.

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

October 2, 2009

30. Name and address of person who completed cause of death (Item 23a)

Donna M. Vincenti, MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year PERRY 0577 AM BURSTYN October 2057 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Sinciltospital a Balt nure Baltimore N/A If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 04/15/1914 9. Birthplace (State or Foreign POLAND 1 X M 2 □ F Months Days Hours Min. 212-44-2019 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 □ Yes 2**X**□ No BALTIMORF BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21209 6513 WICKFIELD ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2X No Specify. WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWNER DELICATESSEN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) YERMIYAHU BURSTYN **ESTHER** NUREMBERG 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6513 WICKFIELD ROAD, BALTIMORE, MD 21209 TOBA BURSTYN/WIFE 20b. Place of Disposition (Name of LOBAWITT TO NUSAL HACE) ARI (NER TAMID) CEM. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/06/2009 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of FacilitSOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Congestino disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 23e. Did tobacco use contribute to the cause of death? art I. 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 100 1 □ Yes muma

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

10a. State

Director MD

Funeral

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Medical Certification: To

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injury or other traumatic event, the Mudical Exemitive nast be nutified at

permit. Pages 1 and 2 should be filed within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event.

Baltimore, Maryland 21215-0036

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be executed and buriatfaw requires that the death certificate the attending philon at the signed by t d be detach

Box 68760

P.0.

Division of Vital Records,

To the Hospital or Attending

page 2 certificate dire funeral After within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

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rt II. Other significant con	ditions contributing to death but not re	sulting in the underlying cause given	in Pa
Stroke,	Hypertensin.	plental effusi	ica

25. Was case referred to medical 26. Place of Death (Check only one)

	1 Yes 2 ₩	0	Но	spital:
27.	Manner of Death			28a. Da
	1 Natural	5 Pending		(Mo
	2 Accident	investigation	1	

Inpatient 2 ER/Outpatient 3 DOA te of Injury onth, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

29a. Certifier

1E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

29b. Signature and title of certifier

RES-000

29d. Date signed (Month, Day, Year) October 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital of Baltimore Sinal Registrar's Signat

State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND TTEM# 16b, perFH, G896, 1078/09, WS
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** M Cooper III 2009 8:15a S. 10 Alexander /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Joseph Richey Hospice If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours Min 1**X** M 2 □ F Director 214-40-8936 65 01 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 X Yes 2 ☐ No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 U.S.A. 1109 Wedgewood Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 12(Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married 1 ☐Yes 2 ▼ No Specify: Completed by Specify: Black ¥☐ Widowed 4 ☐ Divorced "natural" permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Aerospace Elementary/Secondary (0-12) College (1-4or 5+) Bowen Airospace Quality Inspector <u>12th grade</u> 6vrs Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mattie Freeman Alexander Cooper 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6731 Brompton Road, Baltimore, Md 21207 Charles Cooper-Brother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/9/09 Baltimore, Md On-Site 21. Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 21215 ) writh 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause or each line. Approximate Interval Between Onset and Death 2 UTS Immediate Cause (Final disease or condition resulting in death) **Physician** carcinoma metastat /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). that the death certificate be executed Due to (or as a consequence of): Box 68760attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 ☐ Other (specify) the o 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Records, The law requires 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes 2 12 No I or Attending Physician: after death. Director: After this certifica 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Dother (Specify) Hospice 1∐Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) October 2, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

150 31. Date filed (Month, Day, Year).

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Vital

Richey Hospice

838 N. Entaw St Bultimore MD 21201

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			For State	State of Ma		epartment of h		ental Hyg	jiene	
			Registrar  1. Decedent's Name (First, Middle, La	net)		Certificate of	Dealli	2. Date of Dea	th 2	3. Time of Death
	Physici /Medic		Oden Boyd	Crofo	ot		(	Month October	Pay 2009	02112
	Examin	er	4a. Facility Name (If not institution, gi	4.4	Center		Survie		Ange A	
	Funanal		BAltimore Washings 5. Social Security Number 6.		e (In yrs. last birt		If Under 24 Hrs.	8. Date of Birth	9. Bir	thplace (State or Foreign
	Funeral Director			1 🔀 M 2 🗆 F		rs. Months Days	Hours Min.	(Month, Day Sept.	( Year) C	ountry) MD
	yland now		10a. State 10b. County		10c. City, Town	or Location				10d. Inside City Limits
	Maria-fsk	ctor	Maryland Anne	Arundel		C	len Burni	e		1 □Yes 2 □XNo
)	it or 128	Director	10e. Street end Number			10f. Zip Code		1	l 0g. Citizen of What C	ountry?
	sath v	Funeral	10 Normandy Dri	12. Was Decedent I	Ever in LLC	13 Was Decedent of I	21060	oifu Vaa or No	14. Race - Am	
(O	permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It is Medical Eventral must be notified at once.		11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☑ 1		13. Was Decedent of H		Rican, etc.)	Black, Whit	
03	ral", o	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:		Specify: V	Vhite
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<u> a</u>	uld be Menta arked atic ev	To E	George W.	Crofoot			Annie	Mit	chell	
Maryland	2 sho and is ma		19a. Informant's Name/Relationship	(Type. Print)	T	Mailing Address (Street			-	
ے نه	1 and Health Pm 27 ther to	19	Elsie L. Crofoot  20a. Method of Disposition	(spouse		O Normandy Disposition (Name of			e, MD 2106	
nor	ages int of t: If ite		1 ☐ Burial 2 ☑ Cremation 3 ☐		cemeter	y, crematory or other pla	ce) ¦Oct.	05	•	
Baltimore,	artme ortan injury	1 3	4 □ Donation 5 □ Other (Special Signature of Puneral Service Lice	1	Metro	Crematory I			Baltimore, s Funeral 1	4
B	Depared Important Important Info		Auch 10	Haller a	1)	3111			s runeral n sadena, MD	
			23a. Part I. Enter the disease, or con shock, or heart failure. List only	nplications that cause	the death. Do n	ot enter the mode of dyi	ng, such as cardiac o	r respiratory an	rest,	Approximate Interval Between
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•	/Medical Examiner		resulting in death)	Due to (or as	a consequence o	f):				
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P.O. Box	death e atter d for u	iciar	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No	4 Pregnant a	2 Fetal death time of death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	У		Month	Day Year
P. 0	at the de by the tached	hys	9 Unknown	9 Unknown						
S.	To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physcompletely filled in by the funeral director, page 2 should be detached for use as the	þ	Part II. Other significent conditions	contributing to death be	ut not resulting in	the underlying cause give	en in Part I.	23e. Did to	bacco use contribute t es 2XNo 3□ F	to the cause of death?  Probably 4 Unknown
Vital Records,	w requir been s should	Completed								
Rec	he law e has ige 2 s	ршо						24a. Was a autop: perfor	med?   death?	utopsy findings available completion of cause of
tal	ysician: The is certificate hidirector, page	Be Co	25. Was case referred to medical				26. Place of Death	1 Tyes	2 No 1 ☐ Ye	s 2□No
>	Physici this cer al direc	To B	examiner? 1 ☐ Yes 2 █️�️lo	Hospital:	ent 2 ER/Qut	patient 3 DOA Oth	OF:		ence 6 ☐ Other (Sp	ecify)
o u	ding Ph h. After th funeral	on:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Da	ry 28b. T y, Year) In	ijury Wor	k?	28d. Describe h	ow injury occurred	
Division of	ttend death stor: /	icati	2 Accident investigation 3 Suicide 6 Could not to		Inv. At home far		Yes 2□No	Opt Location /C	treet and Number or F	Rum I Pouto Number
Σį	ial or Attendii s after death. al Director: A ed in by the fu	Certification:	4 ☐ Homicide determined	building, etc	c. (Specify)	m, street, factory, office	1	City or Tow		and House Number,
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by th		29a. Certifier  (Check only 2 Medical Exe	hysicien: To the best	of my knowledge	death occurred at the ti	me, date and place,	and due to the	cause(s) and manner	as stated.
	the H hin 24 the Fi	Medical	one)	and manner sta	ated.					
	or or or	2	29b. Signature and title of certifier		4. A	29c. Licens			29d. Date signed (Mor	
	1/		30, Name and address of person who	1//	eath (Item 23a) (	Type Print)	7713		- Clope	7, 200 1
	Ce V				Altimo	re Washin	ton Ma	cical (	Octobe 4 Center	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	ar's Signature					
	Registr	ar	OCT 08 2009	General p	1. par	es .			·	

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 1 Month Physician Batoul Dadashloo 042009 3:50 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Shady Grove Hospital Montgomery Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10/23/1948 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Funeral Months Days Hours Min 1 □ M 2 🔀 F Yrs. 213-98-9740 60 Director Iran Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show ed other than "natural", or items 23a or 28a-f showers, the Walical Examination to matter a 1 ☐ Yes 2 ☐ No MD Montgomery Germantown Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12004 Leatherbark Way 20874 USA within 72 hours after death "natural", or items 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Specify 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "in any injury or other transmission." Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gharibali Dadashloo Shahnbanooh Dizagfarhood 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hooman Piroozmand / Son 23213 Observation Dr., Clarksburg, MD 20871 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Surial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) Parklawn Memorial 10/7/09 Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Universal Mortuary Inc. We 411 Kennedy St. NW, Washington, 23a. Part1. Enter the disease, or complications that caded the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Myocardial Infarction month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Box 68760. attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) P.O. 1 ☐ Yes 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performed? page certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital ¥∏Yes 2☐No Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) Certification: To 1 ☐ Inpatient 2 ☐ XER/Outpatient 3 ☐ DOA this After th funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No after death.

Director: A in by the fi 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide filled in Hospital 124 hours a 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completely fi Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 100064068 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amit Kalaria, 9901 Medical Center Dr., Rockville, MD 20850 MD 31. Date filed (Month, D 32. Registrar's Signature State

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Registrar

State

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29h. S

gnature and title of certifier

osemanie 31. Date filed (Month, Day, Year)

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@0 E1 and address of person who completed cause of death (Item 23a) (Type, Print

32 Registrar's Signature

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 12:47 A M 2009 Hope Day /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number Examiner Daltimore N/A laryland Hospita Jienera 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Min. 1 □ M 2 □ F Director Dec 24, 1963 Marvland 219-76-2886 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Exactions must be notified at 1 XYes 2 No Director Baltimore Maryland n/a 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 624 North Monroe Street 21217 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify Specify Black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any Injury or other traumatic event, In-1 once. Homemaker 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shirley Day Leon Pearson P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1625 Appleton street Baltimore, Maryland 21217 Lynette Fields more, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐xBurial 2 ☐ Cremation 3 ☐ Removal from State 10/09/09 Lansdowne, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cemetery 21. Signat Funeral Service Ucensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failule. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ndocarditis Infective **Physician** /Medical Due to (or as a consequence of): Examiner Lmmunod Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Box 68760. Physician/Medical attending ph IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 4 Pregnant at time of death 5 Other (specify) 1 ☐Yes 2 ☐ No the 9 Unknown 9 Unknown á signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s autopsy performed' certificate 2 No 2 10 1 Yes 1 ☐ Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 **A** 1 Thipatient 2 ER/Outpatient 3 DOA မ this funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? After t Certification: 1 ANatural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

P.0. Records. of Vital Hospital or Attending Physician: Division within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

State

Registrar

Medical

RAHULKUMAR 31. Date filed (Month, Day, Year) 08 2009

29b. Signature and title of certifier

(Check only one)

G. , MARYLAND GENERAL HOSPITAL 827 LINDEN AVE, BALTIMORE MD 21252 32. Registrar's Signature

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month, **Physician** Year Joseph D. Ellis entember 30 200 /Medical 4a. Facility Name (If not institution, give street and number 4b. City. Town, or Location₅of Death 4c. County of Death Examiner Ba iare Hosbito 0 50 7. Age (/n y 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 212-13-9739 XXM 2□ F Months Days Hours Min Director Sept.12,1986 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 shou-d be filed within 72 hours after death with the Maryla D-partment of Health and Mental Hygiene. D-partment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination ust be rutified at MD Baltimore Dundalk Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2033 Bear Ridge Apt. 204 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2XI If Yes, Give Year or Dates: 1 XNever Married 2 ☐ Married 1 ☐ Yes XXNo Specify: \$ Specify: Black 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Enterprise College (1-4 years Elementary/Secondary (0-12) Detailer Rental Car 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) Be Derrick Ellis, Carolyn Nolan ပ 19a. Informant's Name/Relationship (Type. Print) Helen B. Nolan/Grandmother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Waldmann Mill Ct. Nottingham, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park 10/7/09 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 4210 Belair Road Baltimore, MD 21206 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner George tally list or alliens, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and burial-trar Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Ye ar Month Day □Yes 2□No 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy perform 1 ☐ Yes 2 🗆 No 1 □Yes 2 **X**No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 npatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury investigation 1 ☐ Yes 2 ☐ No Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

law requires that the death certificate be execufed Box 68760. P.0. ed by the detached t signed I Records, has certificate Division of Vital Physician: After Hospital or Attending death. n 24 hours after death. le Funeral Director: A bletely filled in by the fu completely within 2

with the Maryland

Joseph L Baltimore, Maryland

State

Medical

29a, Certifier

(Check only

29b. Signature and title of certifier

Registrar

Date filed (Month, Day, Year) OCT 08 2009

-rankti 32. Registrar's S

000

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

36663

Square Drive

29d. Date signed (Month, Day, Year)

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Obert Lason	1- For State Certificate of Registrar Certificate O		Reg. No.	100 200
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  Robert Fasen		2. Date of Death Month Day Year October 4, 2009	3. Time of Death 0952 hrs
	4a. Facility Name (if not institution, give street and number) Sinai Hospital	4b. City, Town, or Location of Death Baltimore	4c. County of Di	eath //A
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)  217-66-6509 1 M 2 F 52 Yr.	If Under 1 Year If Under 24Hrs.	8. Date of Birth (MM/DD/YYYY) 9.	Birthplace (State or Foreign Country) Maryland
nd how any ce.	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Loca  Maryland  NA	Baltimo		10d. Inside City Limits 1 Yes 2 No
tith the Maryland 23a or 28a-f show notified at once.	10e. Street and Number 2607 W. Belvedere Ave.	10f. Zip Code 21215	10g. Citizen of What 0	Country?
iter death wir, or items er must be	1 Never Married 2 Married Armed Forces? If \( 1 \) Yes 2 No 3 Widowed 4 Divorced If Yes, Give Yeer or Dates:  15. Decedent's Education (Specify only highest grade completed) 16a. Decede	nt's Usual Occupation (Give kind of v	Rican, etc.) White, et Specify: work done 16b. Kind of Busine	Black
11215-0036 It be filed within 72 hours at fental Hygiene. Tarked other than "natural event, the Medical Examin	Elementary/Secondary (0-12) College (1-4 or 5+)	nost of working life. DO NOT use retined to the spitality	Privata	e
ID 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medica To Be Comple	17. Father's Name (First, Middle, Last) Chester Eason	France	(First, Middle, Maiden Surname)  S  Burley	
e, MD 21 L and 2 should Health and Mer item 27 is man traumatic ev	19a. Informant's Name/Relationship (Type, Print)  19b. Mailir  496	g Address (Street and Number or F Edgemere Av		Marylard Marylard
more Pages 1 ent of Fi nt: If i	1 UBurial 2 Cremation 3 Removal from State crematory or o	Cemetery 101	112/09 Landsdo	we Maryland
	23a. Part I. Enter the disease, or complications that caused the death. Do not enter	Name and Address Facility Far 572 Frederick F	tve. Battimore,	Varyland proximate Interval
Physician /Medical xaminer	failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):			Between Onset and Death
ner	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause			6
uted ansit Examine	(Disease or injury that initiated events resulting in death) Last  C. Due to (or as a consequence of):  d.		····	
760, Trate be executed g physician and the burial - transit I/Medical Exi	■ AMENDED 23a,pt.II,27,	28a-f per me g89		
Division of Vital Records, P.O. Box 68760, to the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transfered Certification: To Be Completed by Physician/Medical E	past 12 months?	etal death 3 Ectopic pregna	ancy 23d. Date of del Month	livery Day Year
P.O. Es that the canada by the edetached	Part II. Other significant conditions contributing to death but not resulting in the Liver Cirrhosis	underlying cause given in Part I.	23e. Did tobacco use contribut	te to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted by estification: To Be Completed by Fartification: To Be			autopsy prio performed? dea	re autopsy findings available r to completion of cause of th?  Yes 2 No
tal Recicion: The certificate rector, page	25. Was case referred to medical examiner?   Hospital: 1   Innation: 2   ED/Outpation	26.Place of Death (Check	only one)	
n of Vi ding Physi After this funeral di	27. Manner of Death 28a. Date of Injury 28b. Time of		ng Home 5 Residence 6 0	Other:
ion ttendin leath. tor: A the fur	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation 10-4-09 0900	hrs 1 Yes 2X No	unknown	
Division or spiral or Attending to the safer death.  The safer death of the safer death or the safer death o	3 Suicide 6 X Could not be 4 Homicide 6 X Could not be determined (Specify) residence	28f. Location (Street and Number of Town, State) 2607 W. Baltimore, Md.	or Rural Route Number, City Belvedere T	
To the Hosp within 24 he run completely I Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurrence) Wedical Examiner: On the basis of examination and/or investigation.			
Mec 5 5 5 5	and manner stated.  29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed October 5, 20	(Month, Day, Year)
	30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Per	nn Street, Baltimore, MD 21	201	
State Registrar	111 1 13 75 2111394 1 772	No.1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2009 Physician/ OCT Month MARIE ELIZABETH FREEZE 6 :48AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death GILCHRIST HOSPICE BALTIMORE TOWSON Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Maryland Months Hours Min. (Month, Day, Year, 1 M 2 F 219-20-7121 Yrs Sept. **Director** 83 1926 Usual Residence of Decedent or 28a-f show 10b. County 10c. City, Town or Location ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10a. State 10d. Inside City Limits Director 1 Yes 2xXNo Maryland Baltimore Baltimore County 10e, Street end Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1301 Molesworth Rd. 21120 USA 12 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black White, etc. 1 Never Married 2 Married ģ 3altimore, Maryland 21215-0036 White Yes. Give 1 Yes 2 No Specify. Specify: 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Elementary/Seconday (0-12) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me life. DO NOT use retired) yrs. Homemaker Homemaking-Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carl Goemmer Catherine Laudenklos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Brigham (Daughter) 1301 Molesworth Rd. Parkton, Md. 21120 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 10-9-2009 Baltimore, Md. 21. Sign ure of Funeral Service Licensee <sup>22.Name and Address of Facility</sup> Lassann Funeral Home 7401 Belair Rd. Baltimore Hou 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician Te to (or as a consequence of) disease or condition recks Medical resulting in death) Examiner minus 4 car Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence on Exami physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be. 24 hours after death.
Property of the property of Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Day תופו מוא certificate has been signed by i funeral director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed distate 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☒ No Be 26. Place of Death (Check only one) Hospital: Other: မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specify) 27. Manner of Death Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Certificate: 1 🖎 Natural iniury 5 Pending ☐ Accident Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide 28f. Location (Street and Number or Rural Route Number. determined Medica Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my original double coursed at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one 29b. Signature

State Registrar

0

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

LES

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

M NOSEM

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of Ma	aryland		rtment of F tificate of		Mental H	ygiene Reg. No. (	2000	20000
		1. Decedent's Name (First, Middle, L	ast)					2. Date of D Month	eath Day	Year	3. Time of Death
Physic /Med		Roger	S		Fri	ltz		Octobe	r 6,	2009	8:20 P M
Exam	iner	4a. Facility Name (If not institution, g	ive street and number)			•	r Location of Deat	h		ounty of Death	1.1
		8135 Silo Court  5. Social Security Number 6.	Sex 7. Age	e (In yrs. lasi	t hirthday)	Severn If Under 1 Year	if Under 24 Hrs	. 8 Date of B		ne Aruno	
Funera Directo		218-26-1269	1X M 2 □ F	79	Yrs.	Months Days	Hours Min.		17, 193	30 Coun	lace (State or Foreign try) MD
ıland ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, 7	Town or Loc	cation				1	0d. Inside City Limits
Mary a-f sh	ţċ	MD Anne A	rundel	Seve	rn						1 □ Yes 2 💟 No
th the	Director	10e. Street and Number				10f, Zip Code			10g. Citize	n of What Coun	try?
ath wi		8135 Silo Court				21144			U.S.		
er de	Funeral	11. Marital Status	12. Was Decedent I Armed Forces?		13. V	Vas Decedent of H Yes, specify Cuba	lispanic Origin? (S an, Mexican, Puer	Specify Yes or N to Rican, etc.)	0- 14	<ul> <li>Race - Americ Black, White, e</li> </ul>	
036 Irs aft	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1∭Yes 2 ☐ N If Yes, Give Year or Dates:	NO	1	□Yes 2X No	Specify:		S	pecify: Whi	te
Maryland 21215-0036 d 2 should be filed within 72 hours after death with the Maryland lth and Mental Hygiene. 27 Is marked other then "natural", or items 23a or 28a-f show traumatic event, it e Modical Exp. liter must be a diffind at	Completed	15. Decedent's i	Education	1 1	16a. Deced	ent's Usual Occup	oation	skina	16b. Kind	of Business/Inc	dustry
ithin he.	ald m	Elementary/Secondary (0-12)	College (1-4or 5	+)	`life. [	OO NOT use retired	danny most or wo	rking			
d 21 lled w Hygie ther ti	S	17. Father's Name (First, Middle, Las	1		Self	Employed	18. Mother's Na	me (First Middl		ano Rep	air
and d be f ental l ked of	Be	Roland Fritz					Ruth Fu		e, ivialueri ot	imame)	
arylan should be ind Mental marked o	은	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailin	g Address (Street			ber, City or 7	own, State, Zip	Code)
		Mrs Mary Fritz	/Wife		8135	Silo Co	urt Seve	rn, MD	21144		
Baltimore, I bermit. Pages 1 and Department of Heali mportant: If item 2 any injury or other		20a. Method of Disposition  12 ☐ Cremation 3	Removal from State	20b. Plac	ce of Dispos netery, crem	sition (Name of natory or other place	oe) Octo	Date ober 14		ition - City or To	wn, State
timor t. Pages tment of tant: if it		4 ☐ Donation 5 ☐ Other (Spec	eify)	Cres		n Mem.Gar		009	Marri	ottsvil	le, MD
Baltimore, permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other		21. Signature & Funeral Tervice Lice	ensee M			Name and Addre					
		23a. Part 1. Enter the disease, or co	mplications that caused	the death.						Burnie	, MD 21061 Approximate
Physician		23a. Part 1. Enter the disease, or co shock, or heart failure. List onl Immediate Cause (Final	/2	/	P		.5,	,	,	1	Interval Between Onset and Death
/ /Medica		disease or condition resulting in death)	a. Due to (or as	a consequer	ance of):					-	9 mos
Examine		Sequentially list conditions	b	0.	,						
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause Education Cause (Disease or injury	Due to (or as	a consequer	nce of):						
xecute and I-trans	Examiner	that initiated events resulting in death) Last	c Due to (or as	a consequen	rce of):						
68760, ificate be execute physician and sthe burial-trans				<b>-</b>							
68 tifficat tig phy as the	ledical										
Box 68 eath certific attending p	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pregnanc	ev.		23	d. Date of delive	
O. Enhe dea	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown			Other (specify)				Month	Day Year
hat the sed by detach		Part II. Other significant conditions	contributing to death bu	ut not resultir	na in the ur	derlying cause giv	en in Part I.	23e. Did	tobacco use	contribute to the	ne cause of death?
VITAL RECORDS, P.O. Box 68760, ician: The law requires that the death certificate be executed certificate has been signed by the attending physician and rector, page 2 should be detached for use as the burial-transit	d by	ASCUD,	COPD		· · · · · · ·	seri, ing sauce gir					ably 4 🗌 Unknown
w red	Completed							24a. Wa	s an	24b. Were auto	psy findings available
The law	mo							aut	opsy formed 2 No	prior to co death? 1 ∐Yes	mpletion of cause of
VITAL RE sician: The la certificate ha irector, page 3	Be C	25. Was case referred to medical examiner?					26. Place of De			1 🗆 165	2
ohysic this co	ျ	1 Yes 2 No		ent 2 ER			4 LI Nursing I	,		☐Other (Specif	y)
or Attending Physafter death.  Director. After this in by the funeral di	Certification:	27. Manner of Death  1 Natural 5 Pending	28a. Date of Inju (Month, Day	ry y, Year) 28	Bb. Time of Injury	28c. Injui Wor	yat k? Yes 2 ⊡No	28d. Describe	how injury o	occurred	
Attern death ctor	fical	2 Accident investigati 3 Suicide 6 Could not	be 280 Place of Init	ıry - At home	ə, farm, stre		Tes Z INO	28f. Location	(Street and	Number or Rura	l Route Number,
DIV	erti	4 ☐ Homicide determine	building, etc	c."(Specify)				City or To	own, State)		
DIVISION Of VITA  To the Hospita or Attending Physician: within 24 hours after death.  To the Funeral Director After this certific, completely filled in by the funeral director,	Medical (	(Check only 2 Medical Ex	Physician: To the best of the basis of the basis of	f examination	edge, death	occurred at the ti	me, date and place	e, and due to thurred at the time	ne cause(s) a e, date and p	ind manner as s lace, and due to	stated.
o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner sta	ited.		29c. Licens	e number		29d. Date	signed (Month,	Day, Year)
F 3 F 8		1 /A /A MAD.	he l	Chn	ha		5841	1			1,2009
10+1		30. Name and address of person wh				Print)					1 -
1	1	Warren Ross 4801	T 4: -				llicott	City MD	21042	2	
Si Regis	ate Irar	31. Date filed (Month, Day, Year)  OCT 0.8 200	9 Penda 9	ar's Signature	bou	2					
		966	7-7-								

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760,

		State of Mar		artment of Healt			=	
	•	For State Registrar	Cei	rtificate of Dea	th	Reg	J. No. (21) 1) 9	32229
Discosial		1. Decedent's Name (First, Middle, Last)			2	2. Date of Death Month	Day Year	3. Time of Death
Physicia /Medio		Terry Lee Gorsche				Sept. 3	30 2009	03:10 P <sup>M</sup>
Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location			4c. County of Death	
		1525 Ramsay Street  5. Social Security Number   6. Sex   7. Age (	(In yrs. last birthday)	Baltimor If Under 1 Year   If Un	der 24 Hrs. 8	3. Date of Birth	N/A 9. Birth	place (State or Foreign
Funeral Director		219-54-4150 1√2 M 2□F	61 Yrs.	Months Days Hou		(Month, Day, 1 Aug. 09	Year) Coul 1948	Iowa
pu »		Usual Residence of Decedent	0c. City, Town or Lo	notion				0d. Inside City Limits
arylar shov	ا <sub>ة</sub>		oc. City, Town or Lo		2			1 ⊈Yes 2 □ No
the M	Director	Maryland N/A  10e. Street and Number		10f. Zip Code	altimor		g. Citizen of What Cou	ntry?
filed within 72 hours after death with the Maryland Hygiene. Hygiene, wither than "natural", or items 23a or 28a-f show ant, the Medical Evancinal must be notified at	Ö	1525 Ramsay Street		212	223		USA	
death	Funeral	11. Marital Status 12. Was Decedent Even Armed Forces?	er in U.S. 13.	Was Decedent of Hispanic If Yes, specify Cuban, Mex	c Origin? (Spec	cify Yes or No-	14. Race - Ameri Black, White,	
or ite	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No		1 □Yes 2 ☑No Spe		,		Nhite
hours tural"		3 ☐ Widowed 4 Lx Divorced Year or Dates:		dent's Usual Occupation		10	6b. Kind of Business/In	dustrv
in 72	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done during i DO NOT use retired)	most of working		55. (1116 0) 540.11005.11	,
y with giene.	mo	Elementary/Secondary (0-12) College (1-4or 5+)		Manager			Tavern	
e filec al Hy f othe	Be C	17. Father's Name (First, Middle, Last)		18. M	fother's Name (	(First, Middle, Ma	aiden Surname)	
Duld b Ment arkec atic e	짇	Leland Duane Gorsch			orena_	Rick		
12 sh h and 7 is m rraum		19a. Informant's Name/Relationship (Type. Print) Gary A. Gorsche (brothe)		ng Address <i>(Street and Nu</i> 3 Mariners Co				
1 and Healt em 2		20a. Method of Disposition		osition (Name of matory or other place)	Da Da		Oc. Location - City or T	
ages ent of t: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State		matory or other place) ematory Inc.	Oct.	005 009 F	Baltimore M	laruland
permit. Pages 1 and 2 should be filled within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If time 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination is to critical at once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee		2. Name and Address of Fa			Funeral Ho	
Depariment Department Important in any irrespondent		blu I st		3111 Mount		-	adena, MD 2	
		23a. Part I. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line.	ne death. Do not en	ter the mode of dying, such	ch as cardiac or	respiratory arres	st,	Approximate Interval Between
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uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	,					
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atten for us	cian,	in the past 12 months?	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)			23d. Date of deli	Day Year
the d	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown						
e law requires that the d has been signed by the le 2 should be detached	by Pł	Part II. Other significant conditions contributing to death but	not resulting in the u	nderlying cause given in P	Part I.	23e. Did toba	acco use contribute to	the cause of death?
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law re as be 2 sho	Completed					24a. Was an autopsy	prior to c	opsy findings available ompletion of cause of
The cate h	Com					perform 1 Yes 2	ed? death? □No 1 □Yes	2 🗆 No
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Phys r this	.To	1 Yes 2 No Prospital 1 Inpatient 27. Magner of Death 28a. Date of Injury	t 2 ER/Outpatie	nt 3 □ DOA   4L			nce 6 Other (Spec	ify)
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Atter er dea ector by the	Certification:	a D Could not be	y - At home, farm, st (Specify)	reet, factory, office	2	8f. Location (Str. City or Town,	eet and Number or Ru State)	ral Route Number,
rs affer al Dir	Cert							
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certified completely filled in by the funeral director; p	ical	29a. Certifier 1 Certifying Physician: To the best of (Check only 2 Medical Examiner: On the basis of	examination and/or in	th occurred at the time, da nvestigation, in my opinion	ate and place, a n, death occurre	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due	stated. to the cause(s)
thin 2 the of the omple	Medical	one) and manner state 29b. Signature and title of certifier	90	29c, License num	nber	29	9d. Date signed (Month	, Day, Year)
F ≥ F 8		Ahram balanson	MID.					
1110		30. Name and address of person who completed cause of dea	ath (Item 23a) (Type,	Print) SHAP	ZON BI	ALANSI	Oct 5,2	
111		IN Al Greens St. Ba	Itimore	MO 212				
Sta		31. Date filed (Month, Day, Year) 32. Registrar	's fignature					
Registr	ar	and an ease being						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #9 Per FH C897 11/10/09 III State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Tranam October 00:40 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner N Hospital Agnes Beltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day 5. Social Security Number 6. Sex 9. Nithhlace State or Foreign 7. Age (In yrs. last birthday) **Funeral** Year) QL Months Days Hours Min. 1 □ M 2 🖫 216-18-3414 . Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b, County 10c. City, Town or Location than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 Nes 2 No altimore Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3320 21227 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Specify. Black 2 Specify: 3 Nidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be mes ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19ą. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health at
Important: If item 27 is
any Injury or other trau MD21045 6011-3 Majors Traham - daightel \_ane olumbia rmione 20b. Place of Disposition (Name of cemetery, grematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Arbutus 1 Surial 2 ☐ Cremation 3 ☐ Removal from State Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1-6. MD2120 0 23a. Fart 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or not iratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner Diffiele Colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine law requires that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown cate has been signed page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 3 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 □Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: t ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural Injury 5 Pending 1 □Yes 2 □ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Box 68760 P.O. Records, Division of Vital SRAIAS within 24 hours after death

To the Funeral Director:
completely filled in by the

INE

State

Cation ZAR 900 31. Date filed (Month, Day, Year)

OCT 08 2009 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Medical Resident, M.D

Registrar

(Check only

29b. Signature and title of certifier

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

24064

Baltimore

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible link. I Ensure All Gopies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Physician enson /Medical 4b. City, Town or Location of Death a Facility Name (If not ins Examiner & Repartitation Ctr Atonsville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day last birthday) 9. Birthplace (State or Foreign **Funeral** 1**X**M 2□F 22066 lano 60 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Atonsu: 11e 1 ☐ Yes 2 Two Funeral Director 10f. Zip Code 10e. Street and Number 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No 5-0036 Specify. Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of life. DO NOT use retired) Elementary/Serfondary (0-12) College (1-4or 5+) of Health and Mental Hygiene. If item 27 is marked other than or other traumatic event, the M and 17\_Father's Name (First, Middle\_Last) Avid CA therine tenson ၀ Mary 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Cgde) Son repperbox L.A. Pasadena, Md EA des Baltimore, //10/1/09 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Department of Important: If any Injury or 4 □ Donation 5 □ Other (Specify) 21. gnature of Funeral Service Licensee 22. N re Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. mmediate Cause (Final disease or condition resulting in death) CANCER PROSTATE Physician METASTATIC /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner death certificate be executed burial-trar Due to (or as a consequence of): P.O. Box 68760, physician the t as IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy Month Day ρ in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) the detached 9 Unknown 9 Unknown þ signed by be detailed 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by PERIPHENAL VASCULAR DISENSE 1 Yes 2 No 3 Probably 4 Unknown page 2 should SEIZURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No DII MOER 24a. Was an certificate has autopsy perform 20 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 □Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? After or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

| Director; / 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Funeral Dir completely filled in To the Hospital within 24 hours Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier PRIMARY CARE 10056948 29 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TANSINDA 300 ARMONT PLACE SuiTE 3 H BAZINONE MO 2/207 AMO 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#5perFH, 6896, 10/20/09, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Austin Daus Hollis, Jr. 18:46 OCTOBER 04 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death IMOREIMO AGNES HOSPITAL N/A If Unde 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 9042 7. Age (In yrs. last birthday) Hours 1 ☐ M 2 ☐ F 86 Mar. 6, 1923 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No MD Baltimore Arbutus 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5207 Benson Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status  $\chi$  Yes 2 No 1943-ffyes, Give Year or Dates: 1946 1 ☐ Never Married 2 🎇 Married 1 ☐Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unknown Plumber Plumbing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Erba Fischer Austin Daus Hollis, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5401 Highview Road, Arbutus, MD 21227 Mark Hollis - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-6-2009 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LOSTRIDIUM DIFICILE PANCOLITIS DAYS Due to (or as a consequence of): ACUTE RENAL FALLURE FROM ACUTE TUBULAR NECROSTS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last CHRONIC OBSTRUCTIVE PULMONARY Due to (or as a consequence of IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ₩nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ → 24a. Was an autopsy perform 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ NO 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation (Month, Day, Year) 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 □ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Division of Vital Records, P.O. Box 68760,

sician and burial-transit 1.24 hours after death.

• Funeral Director: After this certificate has been signed by the attending physician Hospital or

**Physician** 

Examiner

**Funeral** 

Director

show

Director

Funeral

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Completed

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Medical

29a. Certifier

(Check only one)

ed other than "natural", or items 23a or 28a-f show event, the Medical Examination of items

permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "na any lojury or other traumatic event, It a Profite once.

Physician

**Examiner** 

/Medical

death with the Maryland

filed within 72 hours after

Saltimore, Maryland 21215-0036

/Medical

To the within 2

State Registrar 29b. Signature and title of certifier

29c. License number

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Descritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

STIAGNES HOSPITAL SHANNAROSE BALTIMORE, MD NIGRELLE

31. Date filed (Month, Day, Year)

OCT 08 2009

32. Registrar's Signature

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 30,2009 6:00 A September William Jeffrey Holmes 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel 1604 Ruskin Road Glen Burnie If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number Sex 1⁄2 M 2 □ F 8. Date of Birth (Month, Day, Year) July 31,1959 7. Age (In vrs. last birthday Days Hours Months 213-90-2430 50 July MD Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b County 1 ☐ Yes 2 No MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21061 U.S.A. 1604 Ruskin Road 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 🗓 No 3 Widowed 4 Divorced Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Computer Technician Education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lester Holmes Mabel Leeper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mrs Mabel Holmes/Mother 1604 Ruskin Road Glen Burnie, MD 21061 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Oct Data 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Cedar Hill Cemetery 2009 Brooklyn Park, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave.SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not e Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 2 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 🗌 Yes 24a. Was an

**Physician** /Medical Examiner

Physician

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

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23a

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marked other than

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permit. Pages 1 Department of H Important: If ite any injury or ot

Director

Funeral

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Completed

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other traumatic event, the Medical Examinar trust be notified at

within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

as the burial-transit and attending physician nse for cate has been signed by the page 2 should be detached completely filled in by the funeral director, after death.

Director: After the

The law requires that the death certificate be executed

Box 68760.

P.0.

Division of Vital Records,

Exami Physician/Medical Completed Be ္ရ Certification:

IF FEMALE: 25. Was case referred to medical examiner? 1 Tes 27. Manner of Leath Natural 2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

23b. Was decedent pregnant in the past 12 months?

autopsy performed

24b. Were autopsy findings available prior to completion of cause of death?

26. Place of Death (Check only on

1 ☐Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1 ☐ Yes 2 ☐ No

and manner stated 29b. Signature and title of certifier

Hospital:

5 Pending investigation

6 ☐ Could not be

determined

28a. Date of Injury (Month, Day, Year)

29c. License numbe

305

29d. Date signed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Inpatient 2 ER/Outpatient 3 DOA

28b. Time of

State Registrar

Medical

To the Hospital within 24 hours a To the Funeral E

DX

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Year Alex Harris /Medical October 0 2009 6:50 A 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson
If Under 1 Year | If Under 24 Hrs. Baltimore 5. Social Security Number Date of Birth (Month, Day, Year)
Feb 22, 1945 **Funeral** 9. Birthplace (State or Foreign Months 1 M 2 ☐ F Days Hours Min. Director Maryland 216-42-9182 64 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City. Town or Location ed other than "natural", or items 23a or 28a-f show event, the Medical Evandar Fust be notified at 10d. Inside City Limits Director 1 Yes 2 □ No Glen Burnie Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 413 Hideaway Loop 21061 Funeral 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 □ No If Yes, Give Year or Dates: 1 ☐Yes 2 🕱 No <u>م</u> Specify: Black 3 Widowed 4 Divorced Specify. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Private Construction Co. permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Item 2000. Laborer Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) Corrine Smith Alex Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 Hideaway Loop Glen Burnie, Maryland 21061 Carol Harris 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/12/09 4 ☐ Donation 5 ☐ Other (Specify) Lansdowne, Maryland Mt. Zion Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 23a. Part 1. Enter the risease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sepsic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) physician and the burial-transi Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 1 🗌 Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has autopsy performed? res 2 2 No 2 No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑No 1 hpatient 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director; 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ca (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0066584 10 4 09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MITESH TRAMBADIA N. CHAPLES STREET Tonson, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ September 20, 200911:55A M Katie Haynes Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Charles County Civista Hospi**t**al LaP1ata Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min. 577-34-9990 SC **Director** Usual Residence of Decedent show filed within 72 hours after death with the Maryland permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at. 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Charles Waldorf 1 🗌 Yes 2 🔼 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20601 4190 Houchen Place 11. Marital Status Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married þ Yes 2XXNo Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black If Yes, Give Completed 3XXWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Domestic Self Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) ပ္ Caroline Brunson James Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randolph Haynes/Son 4190 Houchen Place Waldorf MD 20601 20a. Method/of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State Grantian 2 Cremation 3 Removal from State Conation 5 Other (Specify) Lincoln Memorial 09/26/2009 Suitland MD ature of Fu eral S rvi Licens 22. Name and Address of Facility Dunn Sons 5635 Eads St. 20019 NE Washington, DC Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. mediate Cause (Final Physician/ Ischemic Heart Disease Medical esulting in death) Due to (or as a consequence of Examiner Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): burial-transit and that initiated events ŵ Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_ in the past 12 months? Pregnant at time of death the Unknown 9 Unknown ģ signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🗌 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 Inpatient 2 X ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 X X latural 5 Pending work death. 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation within 24 hours after death To the Funeral Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

State Registrar 29b. Signature and title of certifier

ahia

11655 WINESUP

08

31. Date filed (Month, Day, Year)

MD

Barker

Tagauri

32/Registrar's Signature

plata

M.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

0050883

Jahra

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** sizzs! October 2009 2485 2 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner atonsville Commons Catonsville If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Min. 1 □ M 2√2 F 220-20-6313 89 Director 1920 Usual Residence of Decedent permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evansian be notified anonce. 10a. State 10c. City, Town or Location Director MD Baltimore Arbutus 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5502 Delores Avenue 21227 United States Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes X☐ No Specify: Specify: ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Waitress</u> Restuarant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) St. Nicholas Daugherty Bessie L. Avery ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14120 Burntwood Rd., Glenwood, MD 21738
se of Disposition (Name of Date 20c. Location - City or Town, State Nancy Harig - Daughter Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) ortaine Park Cemetery 10-8-2009 Woodlawn, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** neumana disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): pital or Attending Physician: The law requires that the death certificate be executed ours after death.

The law specificate has been signed by the attending physician and filled in by the furneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No Medical Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3. Time of Death

Carolina

White

Onset and Deat

Year

October 5, 2009

10d. Inside City Limits 1 ☐ Yes 2 ☐ No

9-40am

5

within 24 hours a

State Registrar (Check only one)

29b. Signature and title of certifier

30. Name and address of person who

6095 Marshalee Dr. Elknolse, Md 21015 en 2. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10b, c.e. &f per Fh g896 10/15/09 TT

Amend Item 10b per fh, g896, 10/08/09dhb

Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ OCTOBER 2009 8:55 PM KATZ LEAH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE CARE If Under 1 Year If Under 24 Hrs. g. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Count 1 🗆 M 2 🗴 F Months Days Hours 10/934 P19/20 88 Director 215-16-5530 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland that and Mental Hyglene. 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location **Garroll** Director Balt Imore SYKESVILLE 1 ☐ Yes 2 🗶 No Baltimore 10f. Zip Code 21208 10e. Street and Number 7 Slade Ave Apt 507 10g. Citizen of What Country? 21784 Funeral USA 1931 ROUTE 32 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Saltimore, Maryland 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) OFFICE WORKER CLERICAL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ **JOSEPH FELZENBERG FANNY** YAKOWITZ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau once. 1931 ROUTE 32, SYKESVILLE, MD JULIAN KATZ / SON 20a. Method of Disposition 20b. Place of Disposition (Name of ARETNGTON CATTURACE AMUNO CONGREGATION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 10/06/2009 BALTIMORE, MD SOL LEVINSON & BROS., INC. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ vastolic ol ROUS disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examiner if any, leading to immediate cause Enter the or linjury Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Dav Year this certificate has been signed by the an director, page 2 should be detached 1 ☐ Yes ∠ ∠ g ☐ Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Hypertensian, Ottrial Fibrillation Congestive 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an heart tailur autopsy Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSO CO 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of Certificate: 28d. Describe how injury occurred 1X Natural injury 5 Pendina 2 Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) ,MO town 31. Date filed (Month, Day, Year)

OCT 0 8 2009 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death KESSLER OCTOBER. 2009 5:45 A M DAVID J 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days Hours 01/124/14921 219-10-8470 88 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits BALTIMORE BALTIMORE 1 Yes 2XXVo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 USA 1 SLADE AVENUE #303 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 X Yes 2 If Yes, Give Black, White, etc. 1 Never Married 2 X Married 2 No WHITE 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SHOE MANUFACTURER CHILDREN'S SHOES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **KESSLER ROSE** HARRY SILESKY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLOTTE KESSLER / WIFE SLADE AVENUE, #303, BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State BALTIMORE HEBREW 10/07/2009 REISTERSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 McH/c 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Physician Medical **Examiner** 

Physician/

Medical

Director

Funeral

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Completed

Be

2

**Examiner** 

Funeral

Director

with the Maryland

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examinations.

Baltimore, Maryland 21215-0036

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral injector, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760

	shock, or heart failure. List only o	ne cause on each line.			Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a Ischemic Car	LimyopAny		Onset and Death
	resulting in death)	Due to (or as a consequence of);	1		1
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	ry disense		que
LVal	Cause (Disease or iinjury that initiated events resulting in death) Last	C. Due to (or as a consequence of):			
dica		I d			
I Secial II INC	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		topic pregnancy her (specify)		23d. Date of delivery Month Day Year
ten by Fi	Part II. Other significant conditions of	contributing to death but not resulting in the under	lying cause given in Part I.		to use contribute to the cause of death?
adimo				24a. Was an autopsy performed	
0	25. Was case referred to medical examiner?		26. Place of Death (Check of	only one)	
2	1 ☐ Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3	DOA Other: 4 Nursing Hom	e 5 🗆 Residence	6 D Other (Specify) Muspice
Cale:	27. Manner of De th  Natural 5 Pending Accident Investigation Suicide 6 Could not b		28c. Injury at work?  1  Yes 2  No	3d. Describe how in	ijury occurred
200	3 Suicide 6 Could not b		factory, office	Bf. Location (Street City or Town, St	and Number or Rural Route Number, ate)
Medica	(Check 2 Medical Exam	rsician: To the best of my knowledge, death occu- niner: On the basis of examination and/or investigati se Practioner: To the best of my knowledge, death	on, in my opinion, death occurred at the	ne time, date and pla	ace, and due to the cause(s) and manner stated.
_	29b. Signature and title of certifier		29c. License number	29d.	Date signed (Month, Day, Year)

TUBER 5 2009

TON SON MI

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

HARVES

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 8 2009 Physician/ Won Jin Lee 0045 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Towson Gilchrist Hospice 8. Date of Birth
(Month, Day, Year)
Jan 28, 1940 g. Birthplace (State or Foreign Sountry) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Funeral 1 X M 2 □ F Hours Min. Months Director 216-23-6081 ms 23a or 28a-f show must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 1 and 2 should be filed within 72 hours after death with the Manyland of Health and Mental Hygiene. The Arriva or items 23a or 28a-f sho ritem 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director 1 Tyes 2 No Ellicott City Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral S. Korea 21043 7901 Brightlight Place 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc 1 Never Married 2 M Married <u></u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Asian 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Hospital Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Bok Gui Oh Suk Jun Lee 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11357 King George Dr. Silver Spring, MD 20902 Stacev Lee/daughter 20a. Method of Disposition
1 ☐ Burial 2 🄀 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o ± 5 Page 1 permit. Page Department of Important: If any injury or once. Final Journey Crematory 10/08/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee colongandones Cremation Service P.O. BOx 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Complications disease or condition resulting in death) Medical Due to (or an a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): and as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last physician Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No for Month Day Year Pregnant at time of death been signed by the should be detached i 1 ☐ Yes 2 L g ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☒ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Hospital Other: 1 ☐ Yes 2 💢 No 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier

Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death

To the Funeral Director: /
completed filled in by the f Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 💢 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2149194 Jut, CRNP October 8,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chales St Towson, 6701 harian 31. Date filed (Month, Day, Year) Registrar's Signature 32. State OCT 08 2009 Bark Registrar DHMH 17 Rev 7/2009 **ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Layton October 5, 2009  $P^{M}$ 1:00 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 2983 Cornwall Road Baltimore Dundalk Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Hours 1**K** M 2□ F Months Director 232-32-6456 81 November 24,1927 West Virginia Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov er than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2 X No Director Dundalk Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with 2983 Cornwall Road 21222 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ▲ I/Yes 2 □ No If Yes, Give Year or Dates: . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: White 3 ☐ Widowed 4X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ne any injury or other traumatic event, if a M-sit once. Elementary/Secondary (0-12) College (1-4or 5+) Production Scheduler Bethlehem Steel 12 years vears 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leslie Layton Sarah Beverly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6951 Belclare Road, Dundalk, Maryland Robert Layton son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State October 8, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Middle River, Maryland Holly Hill Memorial 2009 21. Signature of Funeral Service Licensee Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundlak, Md. oune 21222 complications that caused the seath. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 23a, Part 1. Enter the disease Part 1. Enter the disease of complications that caused the shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER PROSTATE, METASTATIC 7 YEARS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) □Yes 2 No by the a 9 I Inknown 9 Unknown signed by it is be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No this certific al director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 1/2001

State Registrar MD21001

ME

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year)

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1_State	partment of Health and M <i>ertificate of Death</i>	ental Hygiene  Reg. No. 277 19 3 2 2 1
	Registrar  1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year  3. Time of Death
Physician /Medical	Anna B. Lewi		10-03-2009 10:30a <sup>M</sup>
Examiner	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death  Ft. Washington	4c. County of Death Prince Georges
Funeral	Ft. Washington Health & Rehab.  5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	y) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreign Country)
Director	218–30–3933 1 N 2 F 94 Yrs.	Months Days Hours Min.	05-17-1915 Farmville, VA
w	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
Marylan f show	Md P.G. Temple	Hills	1 <b>∑</b> Yes 2□No
ith the Mar or 28a-f st or retified	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
23a c	2401 Southern Avenue	20748	U.S.A.
fer death writems 23a		<ol><li>Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto</li></ol>	ecify Yes or No- Rican, etc.)  14. Race - American Indian, Black, White, etc.
filed within 72 hours after death with the Maryland Hyglene. Whyglene. Wher than "natural", or items 23a or 28a-f show ant, the Modeel Evanding met be notified at the Completed by Funeral Director		1 □Yes 2 XNo Specify:	Specify: Black
ed within 72 hou ygiene. In a medcal ft. In a medcal E.C. Completed	15. Decedent's Education 16a. De (Specify only highest grade completed) (G.	cedent's Usual Occupation ive kind of work done during most of work e. DO NOT use retired)	16b. Kind of Business/Industry
vithin vithin sine.	Elementary/Secondary (0-12) College (1-4or 5+)		Private
filed v Hygic other i	8th 17. Father's Name (First, Middle, Last)	Housekeeper  18. Mother's Name	e (First, Middle, Maiden Surname)
Tey, Wall yild in a LIZIONOOO  1 and 2 should be filed within 72 hours after death with the Maryla f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f shoother traumatic event, the Medical Examinar rust be notified at  To Be Completed by Funeral Director	George Gaines	Mary	L. Carey
2 shou and his ma	, , , , ,		al Route Number, City or Town, State, Zip Code)
C, IN t and 2 Health em 27 other tra	Sheila A. Traynham -Grandaughter 340  20a. Method of Disposition 20b. Place of Dis		Date 20c. Location - City or Town, State
parmit. Pages 1 ar Department of Hee Important: If item any Injury or othe once.	1 X Burial 2 ☐ Cremation 3 ☐ Removal from State	ection Cemetery 10/9	·
mit. P partme oortan Injur.	4 Donation 5 Other (Specify)  21. Vignature o Funeral Service Licensee	22. Name and Address of Facility Ror	ald Taylor II Funeral Home
Deparmi Deparmi Import any ir	Kondol Call II		ne, White Plains, Maryland
	23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac	or respiratory arrest, Approximate Interval Between Onset and Death
Physician	Immediate Cause (Final disease or condition resulting in death)  Sepsis		
/Medical Examiner	Due to (or as a consequence of):  Chronic Sacral U.	lcer	
<b>5</b>	Paguantially list conditions		
executed an and ial-transit	Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
ficate be executed physician and s the burial-transit	resulting in death) Last  Due to (or as a consequence of):		
fficate be physicial to but the bur	d		
ath cert	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy	23d. Date of delivery  Month Day Year
ding Physician: The law requires that the death certified.  After this certificate has been signed by the attending I funeral director, page 2 should be detached for use as fund. To Re Completed by Physician/Median.	in the past 12 months?  1 ☐ Yes 2 ☐ No  9 ☐ Unknown  1 ☐ Yes 3 ☐ Hold death  9 ☐ Unknown	5 Other (specify)	Month Day Year
Hat the ed by detach		e underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
law requires that some as been signed 2 should be considered by	Chronic Kidney Disease		1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown
The law required to the cate has been so page 2 should			24a. Was an autopsy findings available prior to completion of cause of
The la ate has page			performed? death? 1 □ Yes 2 🖺 No 1 □ Yes 2 💆 No
VILIAI iician: T certifica rector, p	25. Was case referred to medical examiner?	Other:	h (Check only one)
Phys Phys r this rat dir	To res 2 Envo	ne of 28c. Injury at	ome 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred
SION tending leath. tor: Afte the fune	1 Matural 5 □ Pending (Month, Day, Year) Inju 2 □ Accident investigation	ry Work? M 1 □Yes 2 □ No	
LIVISION C tal or Attending F rs after death. al Director: After led in by the funer?	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
urs aft		death accurred at the time, date and place	and due to the cause(s) and manner as stated
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Contification	29a. Certifier 1 Certifying Physician: To the best of my knowledge, c (Check only one) 2 Medical Examiner: On the basis of examination and/one) and manner stated.	or investigation, in my opinion, death occu	rred at the time, date and place, and due to the cause(s)
To the within To the complete	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	· ([/ww/\])	D 51520	10-06-2009
21	30. Name and address of person who completed cause of death (Item 23a) (Ty Dr. Bahram Pishdad 1328 Southern		DG 20022
State	31. Date filed (Month, Day, Year)  OCT 0 8 2009  32. Registrar's Signature	n Ave. SE #310 Washi	Ington IC 20032
Registra	OCT 08 2009 General B. Spark		

#### 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Teven /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Annapolis Nursing & Rehab Center Annapolis If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 ★ M 2 F 212-06-7330 May Director 41 03 Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 23a or 28a-f show Injury or other traumatic event, the Medical Examinar must be notified at Directo Maryland Anne Arundel Glen Burnie 10f. Zip Code 10e. Street and Number 1317 Howard Road 21060 Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status □Yes 2 No Yes, Give 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 'natural", or 1 ☐Yes 2 ☑ No þ 3 Divorced 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If Item 27 is marked other than any Injury or other traumetric. Elementary/Secondary (0-12) College (1-4or 5+) 10 Carpenter 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be F. Mickey Lucas Jr. Mary J. P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (mother) 1317 Howard Road, Glen Burnie, MD 21060 Mary Lucas 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 05 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service License Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 Part 1. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 🔲 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident Injury 5 Pending within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐Yes 2 ☐ No investigation

6 ☐ Could not be

determined

3 ☐ Suicide

29a. Certifier

4 Homicide

29b. Signature and title of dertifier

Name and address

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 ZNO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Dav.

3. Time of Death

Birthplace (State or Foreign Country)

MD

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 ☐ Yes 2 ☑ No

PM

Day

1968

Year

Anne Arundel

2009

4c! County of Death

10g. Citizen of What Country?

Specify:

Falice

16b. Kind of Business/Industry

20c. Location - City or Town, State

Elkridge, Maryland

14. Race - American Indian,

Construction

White

Black, White, etc.

State Registrar

Medical

29c. License numbe

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

and manner stated.

person who completed cause of speath (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

Registrar's Signature

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2009 ar OCTOBER **Physician** LEVINE 10:10 A™ JEROME /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OWINGS MILLS BALTIMORE 9940 MIDDLE MILL DRIVE If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/04/1924 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1 X M 2 □ F 85 024-16-7296 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10b. County 10a. State 28a-f show ir than "natural", or items 23a or 28a-f shov the Modical Examinations to notified at 1 ∐ Yes 2 🛣 No OWINGS MILLS Director MD BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21117 9940 MIDDLE MILL DRIVE by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: WHITE If Yes, Give Year or Dates: 3 ☐ Widowed 4 🂢 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) within 72 d 2 should be filed within 7 th and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) MEN'S CLOTHING SALESMAN 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked tany injury or other traumatic ew GEORGE LEVINE ESTHER ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 344 OVERLOOK LANE, GULPH MILLS, PA DEBORAH LEVINE / DAUGHTER Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HILLTOP SERVICE CORP. 10/07/2009 TOWSON. MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VEARS **Physician** ADVANCED ALZHEIMER'S /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): sician and burial-transit law requires that the death certificate be executed Due to (or as a consequence of) cate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 2 No 3 Probably 4 Unknown HYPERUPIDEMIA 1∏Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 1PHERAL VASCULAR DISEASE 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No or Attending Physician: funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d, Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 5 ☐ Pending investigation 1. Natural ours after death.
neral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral I

completely filled To the Hospital 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCTEBER 5 , 2009 1 MR Bolils D0054653 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOLLY R. DAI+LMAN, MD 216 - WITHERVILLE, HD 21093 JOPP 4 ROAD SUME 31. Date filed (Month, Day, Year) State OCT 0 8 2009 Registrar

(OSMICK, E 3 promer 13 Patri

DHMH 17 Rev 1/2001

1. Decedent's Name (First, Middle, Last) Day Year 1149 AM **Physician** McCormick Fannie September 30 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore City Sinai Hospital of Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 □ F 82 Yrs. 214-22-9021 18 MD 01 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once. 1 ☐ Yes 2 No Director Owings Mills Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21117 U.S.A. 4729 Dark Star Way Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 2 X No 1 Never Married 2 Married 21215-0036 1 □Yes 2X No If Yes, Give Year or Dates: Specify: Specify: Black ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Private 12th grade Seamstress na 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be Bessie Mason Hinter Harris ျ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4729 Dark Star Way, Owings Mills, Md 21117 George Lee McCormick-Son Baltimore, 20b. Place of Disposition (Name of Kingmillemore x ProParke) Arbutus Memorial 20c. Location - City or Town, State Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 10/10/09 Arbutus, Memorial 4 □ Donation 5 □ Other (Specify) 21. Signature of Enperal Service Licensee 22. Name and Address of Facility
March F/H West Tynette K. fines 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 2 days Physician 1 /Medical Due to (or as a consequence of): 18 day Examiner Selsis Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Lause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 🗆 Ectopic pregnancy Year Month Dav 5 Other (specify) signed by the a d be detached for P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Mybertension 24a. Was an autopsy performed? Yes 2 1 has 1 ☐Yes 2 ☑ No certificate 1 ☐ Yes Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ № 0 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 24 hours a er death.
e Funeral Director: After this of letely filled in by the funeral dire Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manper of Death Injury or Attending 5 Pending investigation 1 M Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Hospital completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Sunt Kaperage. MBBS September 30, 2009 9620 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sirai Baltimore Dr. SUMIT KAPOOR 32: Registrar's Signature 31. Date filed (Month, Day, Year) State OCT 0 8 2009 Registrer

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

2. Date of Death

3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #IAMEND ITEM#4a, perPHYS#10e, perFH, G896, 10/16/09, WS State of Maryland Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Gregory Edward Masi Year Month **Physician** 2:00 P Greg Edward Masi Oct 6, 2009 /Medical 4a. Facility Name (If not institution, give street and number).
Williamfield Dr. 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ellicott City Howard 13136 Williams Field Dr. Birthplace (State or Foreign Country) If Under 1 Year Months Days If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1**√**1 M 2□ F Months 578.72.9180 Yrs. Wash, M Director 57 Apr 9, 1952 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event. Its Markal Evan in a 19 a rottling at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2 No Director **Ellicott City** MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Williamfield Dr. U.S.A 21042 Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ♣Never Married 2 ☐ Married Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Commercial Real Estate Executive Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ဥ Lawrence J. Masi Margaret L. Trilling 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7961 Pond Haven Lane Saint Michaels, MD 21663 Lawrence Masi Brother Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Gremation 3 ☐ Removal from State Oct 07, 2009 4 ☐ Donation 5 ☐ Other (Specify) Glen Burnie, MD Atlantic Crematory, LLC 22. Name and Address of Facility nature of Funeral Service Licensee Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City.
23a. Part 1. Enter the dis. lest, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Slack Funeral Home, P.A. 3871 Old Columbia Pike Ellicott City, MD 21043 Approximate Interval Between Onset and Death Immediate Cause (Final MUTUSTAT Physician Canti Z CAIN Can much disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 

Yes 2 

No 3 

Probably 4 

Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 □Yes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) the funeral 28b. Time of 27. Manner of Death 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 🕅 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide within 24 hours To the Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[Image: Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier completely (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certific 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6020

DHMH 17 Rev 1/2001

State Registrar

Nicholas

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Koutrelakos

MI) 32. Registrar's Signature Charter

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1/perff, G896, 10/8709, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Marceleine McCo October 10.10PM 2004 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Sinai Hospital of Baltinure Ba Honore If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Month, Day,
M9.31, 7. Age (In yrs. last birthday). 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign **Funeral** Maryland -38-844 1 □ M 2 □ M Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov the Medical Examiner must be notified at 1 Yes 2 No Completed by Funeral Director Maryland 10e. Street and Number 10f. Zip Code #310A 10g. Citizen of What Country? ō Windsor Garden Lare "natural", or items 23a Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☑ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Health Care Provider 17. Fath Danie First, Wilkins 18. Mother's Name (First, Middle, Maiden Surname) Be Wilson 19a. Informant's Name/Relationship (Type. Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health a Important: If item 27 Is any injury or other trau Ave. #103 Faula Whit W. Tropicar as Vegas. Nevado 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Man Metro Cremato 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Win 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Bistress Respiratory month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence or, Examine physician and s the burial-trans Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. requires that the death certificate be Physician/Medical as attending p IF FEMALE: nse s 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) ☐Yes 2☐No After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Kidney Dixxo 2 No 3 Probably 4 Unknown Completed 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ 100 24a. Was an autopsy performed? Yes 2 No Obstructive Chromic 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death
To the Funeral Director:
completely filled in by the 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MI RE3-000 October 1, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Amadeo MO Sinai Hospital of Baltimore 31. Date filed (Month, Day, Year)

OCT 08 2009 32. Registrar's Signatur State Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year ARBARA MATOSKA 10 0530 M 09 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Social Security Numbe If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, May 19, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Months Days Min. Hours 1 □ M 2 🗹 215-28-1658 78 1931 Maryland Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Mudical Examiner must be notified at annies. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Baltimore Md. White Marsh 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 8100 Rossville Blvd. 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tyes 2 XNo à Specify: Specify: 3X Widowed 4 ☐ Divorced White Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Physician Billing Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William Youngman Mary Worg မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Susan Dohony/ Daughter 7910 Hampton Way Owings, Md. 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Parkwood Cemetery 10-09-2009 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or of implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final NIRA CENEBRAL HEMORRATAGE acute/cho **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>გ</u> 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No has r this certificate h 1□Yes 2☑No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 | Yes 2 | **N**o 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Natural 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident after death

Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) in 24 house. the Funeral Direct 4 Homicide

State Registrar

29a. Certifier

(Check only one)

29b. Signature and title of certified

Medical

within 2

and manner stated

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ne and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

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29c. License number

29d. Date signed (Month, Day, Year)

ANNAPOLIS MOULE

106. 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October Day. 2009 12:14 Nolan James Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Stella Maris Timonium 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 4M 2 4 F Months Hours Min. Dec 15, Year) 922 MaryTand 213-14-8260 86 Director Usual Residence of Decedent shov 10a, State 10c. City, Town or Location at 10d. Inside City Limits Director 28a-f Examiner must be notified MD Baltimore Timonium 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 0 10g. Citizen of What Country? 23a Funeral 2525 Pot Spring Road #5423 21093 U.S.A. items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. Armed Forces?

1 XYes 2 No "natural", or þ 1 Never Married 2 XMarried 1 XYes 2 No If Yes, Give 43-45 Year or Dates. 3altimore, Maryland 21215-0036 1 Yes 2 No Specify: White 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Attorney Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nolan Patrick J. Rose Walsh OCTOBER 7, 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dolores M. Nolan-wife 2525 Pot Spring RD, #5423 Timonium, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕱 Burial 2 🗆 Cremation 3 🗆 Removal from State Druid Ridge 10/10/09 4 Donation 5 Other (Specify) Baltimore, MD 21. Signature of Funer | Service | S 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Dau 1050 York Rd., Towson, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician PARKINSONS DISEASE Medical resulting in death) Due to (or as a consequence of Examiner PROSTATE CANCER Sequentially list conditions, Examine Due to for es e consequence of cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death ed by the a 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. signed by be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. JAMES NOLAN 23e. Did tobacco use contribute to the cause of death? by Completed 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si irector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other:  $_4$   $\square$  Nursing Home 5  $\square$  Residence 6  $\mathbf{X}$  Other (Specify) **HOSPICE** 1 Tes မ 2 **X** No 1 🗌 Inpatient 2 🗌 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After of completed filled in by the funeral 1 X Natural 5 Pending Investigation 6 Could not be 2 L Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29d, Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

JONES,

VALLEY RD.

TIMONIUM, MD 21093

completed cause of death (Item 23a) (Type, Print)

2300 DULANEY

32, Registrar's Si

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygierie ( ) ( ) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 05, 2009 **Physician** 1:10 p M William Η. 01sen /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Towson 800 Southerly Rd. #1808 8. Date of Birth Nov 21, 1922 If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral Months On To 86 287-16-1878 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Health and Mental Hygiene. tem 27 is marked other than "netural", or Items 23s or 28s-1 show ther traumetic event, I'm Medical Exarcing must be notified at 1 ☐ Yes 2 No Baltimore Towson Md. Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21286 800 Southerly Rd. #1808 Funeral death 12. Was Decedent Ever in U.S. Armed Forces?

1X Yes 2 □ No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: þ 3X Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Minister Church 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fill thent of Health and Mental Hent: If Item 27 Is marked oth jury or other traumetic even 18. Mother's Name (First, Middle, Maiden Surname) Be Hill Natalie Clarence 01sen ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1091 Cherry Orchard Rd. Dover, Pa. 17315 19a. Informant's Name/Relationship (Type, Print) Thomas Olsen/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State permit. Page Department of Importent: If eny injury or once. Hilltop Service Co. 10-7-09 Towson, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Fundal Servi 22. Nam Ranckdor Towsoff Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final mitral Value Endocarditis **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760, Physician/Medicai as IF FEMALE use 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) of Vital Records, P.O. 9 Unknown signed by detache 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pneumonia 2 No 1 🗌 Yes 3 ☐ Probably 4 ☐ Unknown heart failure End stage congestive 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Jas Lymphoma certificate 1 🗌 Yes the Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) 일 27. Manner of Death

1 Natural
2 Accident 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 28b. Time of 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation after deatl Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours aft B Funerel DI letely filled in Medicai 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 3 CRNP within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Schen CRNP R154032 30. Name and address of puson who completed cause of death (Item 23a) (Type, Print) Baltimore, IND 21286-8403 800 Southerly Road 22. Registrar's Signature 31. Date filed (Month, Day, Year) State Beven & parked Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** 12:05AM M Vivian Peddicord October 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Morningside House Assisted Living Hanover Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 M 2 TVF 213-12-3759 Director Maryland June 22 1920 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygiene. actively, or items 23a or 28a-f show ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, it is wasted that Examine must be natified at injury or other traumatic event, it is wasted it examine must be natified at 1 ☐ Yes 2 ☐ No Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 632 Ross Drive 21122 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐YNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: white þ 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administer secretary 12 Steel Indstry 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be David Lloyd Anna Trieschman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vivian Elwood daughter 1411 Wigeon Way Gambrills MD 21054 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or Meadowridge Cem 4 ☐ Donation 5 ☐ Other (Specify) Oct.10 2009 Elkridge Maryland 21. Signature of Funeral Service Livense 22. Name and Address of Facility Stallings Fuenral Home P.A. 3111 Mountain Road Pasadena MD 21122 23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** Men disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) P.0. the 9 Unknown 9 Unknown þ s been signed b should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 2 No 3 Probably 4 Unknown 1 □ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy certificate 1 □Yes 2 □No 1 □ Yes Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' 1 Yes ⊅∆No Other: 4Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Natural After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5027 Rikhie Hry suite 134 Pasadera MO21122 KOUTH 31. Date filed (Month, Day, Year) \$2. Registrar's Signature State

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Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Paul McLaren Pardew, Sr. :33 P M Oct 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Baltimore Towson 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, Yea Nov. 17 Hours Min 1 XM 2 □ F 215-12-7030 Director 91 1917 Usual Residence of Decedent or 28a-f shov 10b Counts 10a. State 10c. City, Town or Location 10d Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director MD Baltimore Towson 1 Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1424 Autumn Leaf Rd. 21286 USA filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. à 1 Never Married 2 X Married Yes 2 XNo Saltimore, Maryland 21215-0036 1 Yes 2 No Specify white Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natur any injury or other traumatic event, the Medical once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Self Employed 4 Sports & Recreation Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) H. Paul Pardew Ruth McLaren Page 1 and 2 should be f 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Patrick Pardew/son 1005 Rayville Rd., Parkton, MD 21120 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State 10/1<sup>2</sup>3709 cemetery, crematory or other place) Baldwin Memorial United Meth. Cem. Millersville, MD 5 Other (Specify) Donation 21. Si del Fyneral Senice Line 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, Inc. W. Padonia Rd., Timonium, MD 21093 Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leadin, to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Year Day 2 No To the Hospital or Attending Physician: The law requires that the des within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the scompleted filled in by the funeral director, page 2 should be detached it 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 X No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: ည 1 TYes 2 000 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27, Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5  $\square$  Pending 1 Yes 2 No Accident

Suicide

Homicide M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗡 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one

State Registrar

DHMH 17 Rev 7/2009

29b. Signature and title of certi-

31. Date filed (Month, Day, Year)

OCT 08 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

7.33pm

681

29d. Date signed (Month. Day. Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 200 gar 3:08 A M Phelps Dolores Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Brighton Gardens Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Min. Nov. 29 1 M 2 V F Months Days Hours Maryland Director 218-26-6642 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 🗆 Yes 2 💢 No Maryland Baltimore Monkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21111 16500 York Road Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian. Armed Forces þ 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: "natural", 3 V Widowed 4 Divorced Completed White Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Schmidt Chason Jeannette 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John H. Phelos 16500 York Road Monkton, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a Method of Disposition Burial 2 Cremation 3 Removal from State
Constitution 5 Other (Specify) 10-10-2009 Timonium Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ moretan disease or condition 100 Medical resulting in death) Due to (or as a onsequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) executed and burial-trar Due to (or as a consequence of) resulting in death) Last physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 the attending phase as as IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown that the death Month Veal Day Pregnant at time of death ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ or Attending Physician; The law requires 2 No 3 Probably 4 Unknown 1 🗌 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed this certificate 1 🗌 Yes 2 🗆 No Yes 2 M 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 No Other: 4 Nursing Home 5 Residence 6 NO Other (Specify) NSS 15 Ted Live ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of FeciliA 28c. Injury at 28d. Describe how injury occurred Certificate: 24 hours after death.

Funeral Director: After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident M Investigation filled in by the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) and title of certifier 29b. Sign 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHALIRS 201 N 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) October 5, 2009 2009 **Physician** 4:23 Рм W. Povleski Robert /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Year) Months Days Hours Min. 1**√** M 2□ F Yrs. 86 13, Pennsylvania Director 183-12-6375 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show event, the Medical Evanimer must be notified at 1 ☐ Yes 2 🕱 No Director Jarrettsville Maryland | Harford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 23a or 21084 U.S.A. 2368 Northcliff Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 No 1 No If Yes, Give 1943 – 1946 Year or Dates: 1 Never Married 2 Married 2 should be filed within 72 hours afte and Mental Hygiene. is marked other than "natural", or I Baltimore, Maryland 21215-0036 1 ☐Yes 2 ☑No Specify. Specify: ģ 3 X Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction General Contractor 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Curran Mary ဂ **Enoch** <u>Povleski</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important; If item 27 is any injury or other trau Monkton, Maryland 21111 2812 Pocock Road <u>Albert J. A. Young</u> 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Pages 1 Highview Memorial 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 10-8-2009 <u>Fallston</u> Maryland Gardens re of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 1050 York Road Hagen 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Smul bowel obstruction remeting in pitched abdominal inform **Physician** /Medical Due to (or as a consequence of) Examiner Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical Hospital or Attending Physician: The law requires that the death certificate 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2☐No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown cate has been signated by page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □Yes 1 □Yes 2 X No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death

1 X Natural

2 Accident 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred After t (Month, Day, Year) 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death Director: filled in by the 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical To the I 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0069080 Danque Kilnards M.D. October, 5, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 1/2001

Tanique Richards
31. Date filed (Month, Day, Year)

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Baltimore MD 21204

			For Amend Ite	m State of Ma	aryland	6 <mark>9191</mark> Cert	18/09ahb ificate of l	lealth a D <i>eath</i>	and M	ental Hyg ¤	iene eg. No.	109	32255
	Dharisi		1. Decedent's Name (First, Middle, La							2. Date of Dea Month	Day	Year	3. Time of Death
	Physicia /Medic		ANN		ABETH		POTHI			October		v of Death	0524 "
	Examin	er	4a. Facility Name (If not institution, gi				4b. City, Town, or		of Death			bot	_
	Funeral		Memorial Hosp 5. Social Security Number 6.	Say 7 Ag	je (In yrs. las	st birthday)	If Under 1 Year	If Under		8. Date of Birth (Month, Day	_		place (State or Foreign
	Director		203-28-3867	1  M 2  F	71	Yrs.	Months Days	Hours	Min.	01/20	/1938	000	PA
	pu v		Usual Residence of Decedent  10a. State 10b. County	,	10c City	Town or Loca	ation						10d. Inside City Limits
	/anyta f shov	ō	MD TAL	вот	100.010		ASTON						1 □Yes 2 X No
	the N	rect	10e. Street and Number				10f. Zip Code				l0g. Citizen of	What Cou	ntry?
	h with	Funeral Director	119 S. HARRISON	STREET			2160	1			US	SA	
	r deat	uner	11. Marital Status	12. Was Decedent Armed Forces? 1 ∐Yes 2 🛣	Ever in U.S.	13. W	as Decedent of H Yes, specify Cuba	ispanic Ori an, Mexicar	igin? (Spe n, Puerto	ecify Yes or No- Rican, etc.)	14. Ra Bla	ace - Ameri ack, White,	can Indian, etc.
36	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at		1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🎇 Divorced	1 □Yes 2 🔼 If Yes, Give Year or Dates:	No	11	□Yes 2 X No	Specify:			Speci	ify: W	HITE
9	2 hour	Completed by	15. Decedent's E	Education		16a. Decede	nt's Usual Occup	ation	t of warki		16b. Kind of E	Business/Ir	ndustry
215	thin 7; ie. ian "n	nple	(Specify only highest g	College (1-4or 5	5+)	`life. D	O NOT use retired	d)	t OI WOIKII	,y	DEAL	FOT	ATE
21	filed withir Il Hygiene. other than rent, Ir	S	12   17. Father's Name (First, Middle, Las			AG	ENT	18 Mothe	are Nama	(First, Middle,		_ EST	AIL
್ರಿ, A∩∩ Maryland 21215-0036	e d da	Be C	HERBERT	*	JACOBS	SON			IZAB			WILS	ON
<u></u>	s 1 and 2 should be f Health and Menta tem 27 is marked other traumatic e	욘	19a. Informant's Name/Relationship				Address (Street				r, City or Tow	n, State, Z	p Code)
2,₹	2 ± 2 ±		MATTHEW WEINER	/ SON		6100	CITY AV	ENUE,	#41	4, PHIL			
Pothic altimore,	ges 1 ar t of Hea If item		20a. Method of Disposition  1 X Burial 2 □ Cremation 3	Removal from State	cer	netery, cřema	tion (Name of atory or other plac			ate	20c. Location	,	
Z . ₩	t. Pag tment tant: jury o		4 ☐ Donation 5 ☐ Other (Spec	rify)	BAL		HEBREW						
Bai	permit. Pages : Department of I Important: If ite any injury or of		21. Signature of Funeral Service Lice	onsog			Name and Addre						, INC. MD 21208
1/4	101		23a. Part 1. Enter the disease, or co	mplications that caused	d the death.								Approximate Interval Between
	Physician		shock, or heart failure. List onl Immediate Cause (Final	y one cause on each li	ine.							1	Onset and Death
	/Medical		disease or condition resulting in death)	Due to (or as	a conseque	ence of):	heart	-					1
	Examiner	L	Sequentially list conditions,	D			heave	17	110	~			1700
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K	execu n and ial-tra	Exar	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or as	a conseque	ence of):					<u> </u>		
8760	cate be executed ohysician and the burial-transit	dical		d									
9	ertifica ing ph e as th	Med	IF FEMALE:					-					
Box	eath certific attending p for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth 4 Pregnant	2 Fetal o	death 3 🗌	Ectopic pregnand	<sub>су</sub>				Date of deli Month	very Day Year
P.O.	the de	ysic	1 □ Yes 2 □ ₩o 9 □ Unknown	9 Unknown	at time of dea	ain 5	Other (specify) _						
	w requires that the d been signed by the should be detached	by Ph	Part II. Other significant conditions	contributing to death b	out not result	ting in the un	derlying cause giv	en in Part	I.	23e. Did to	obacco use co	ntribute to	the cause of death?
rds	quires en sig uld be									101	/es 2 □ No	3 🗆 Pr	obably 4 Unknown
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<u>=</u>	The la	Com								perfo 1 □ Yes	rmed? 2 2 No	death? 1 ☐ Yes	2 🗆 No
Vita	Physician: The r this certificate Fral director, page	Be	25. Was case referred to medical examiner?	Hospital:			a Doa Oth	or:		n (Check only o			
Division of Vital Records,	Phys er this eral dii	2:1	1 Yes 2 No 27. Manner of Death	28a. Date of Ini	urv 2	R/Outpatient 28b. Time of	28c. Inju	ry at		me Residente la 28d. Describe la			cify)
ion	nding Path. r: After e funera	atior	1 Natural 5 ☐ Pending 2 ☐ Accident investigati	( <i>Month, Da</i> on	ay, Year)	Injury	Wor	k? ]Yes 2□	]No				
<u> </u>	r Atte er deg recto	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	20e. Place of III	jury - At hon tc. (Specify)	ne, farm, stre	et, factory, office			28f. Location (3		mber or Ru	ıral Route Number,
Ö	ital or las aft ral Di												atatad .
0	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one)  Certifying 1  2 Medical Ex	Physician: To the best aminer: On the basis and manner s	of examinati	on and/or inv	estigation, in my	opinion, de	ath occur	red at the time,	date and plac	e, and due	to the cause(s)
7	To the To the Comple	Me	29b. Signature and title of certifier	1		7	29c. Licens	-	44	2	29d. Date sig		
				12-	10(1)		00	05,	113		10	. 5-	07
			30. Name and address of person wh					EAC	MOT	MD 04	601		
	Sta	ate.	JORGE ABREGO 31. Date filed (Month, Day, Year)	598 CYNWO				, EAS	OTUN,	רא טויז	601		
	Sta Registi		OCT 08 2009	Deven	A. 1	parko					~		

DHMH 17 Rev 1/2001

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Year **POLLACK** DANTEL 06-20 AM OCTOBER 2009 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) N/A BALTMORE BALTIMORE CITY SIMAI HOSPITAL OF If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 1 X M 2 ☐ F MD 01-04-1924 219-18-1571 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10h County 1 ☐Yes 2 No BALTIMORE **BALTIMORE** MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21209 6711 DARWOOD DRIVE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: WHITE 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) REAL ESTATE APPRAISER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) POLLACK REBECCA HARRY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6711 DARWOOD DRIVE, BALTIMORE, MD 21209 SELMA POLLACK/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BETH EL MEMORIAL PARK 10-07-2009 RANDALLSTOWN, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 Tocoo. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) MYDCARD, AL DAY ACUTE Due to (or as a consequence of): ARTERY DISEASE COROHARY THEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 2 □ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERLIPIDEMIA ACUTE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an HEPATITIS, autopsy performed 1 Yes 2 No DISEASE PAGET'S 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending M 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760. use as ò s been signed by the s certificate has t rector, page 2 s nas To the Hospital or Attending Physician: funeral director. After this after death.

I Director: A in by the fu

**Physician** 

/Medical

Examiner

Director

Funeral

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Physician/Medical

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Medical Certification: To

**Funeral** 

Director

ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at

marked other than "natural", or Items

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item Z7 Is marked oth any Injury or other traumatic event goos.

Physician

/Medical

**Examiner** 

Maryland 21215-0036

Baltimore.

and manner stated

6 ☐ Could not be

(Check only one)

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

000

OF

29b. Signature and title of certifier annon

31. Date filed (Month, Day, Year) 0CT 0 8 2009

RED-

OCTOBER 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

HOSPITAL SINAI BUATIA mD

MD

State Registrar 2. Registrar's Signature

within 24 hours aft

To the Funeral DI

completely filled ir

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, per Fh g897 11/17/09 TT

Amend Item 2,29d per dr., g897 per prince per dr., g897 per prince per dr., g897 per d 1 - For At State Registrar 2. Date of Death 10/06/2009 3. Time of Death 1. Decedent's Name (First, Middle, Last) RICHARDS Dav **Physician** HRIS FOFHER 7:41 AM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE, N/A SHOCK TRAVM (FN/CR COWLEY If Under 1 Year If Under 24 Hrs. 8, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 180 7. Age (In yrs. last birthday) **Funeral** Days 1 M 2 □ F March 11,1970 Maryland Director <del>186</del>-66-8952 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the "natical Exemple: I use be retified at 1 □Yes 2 No Director Maryland Talbot Wittman 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8727 Sewell Point Road 21676 **USA** Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after 0 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Modital Examinations. 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White 2 3 ☐ Widowed 4 🎇 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Businessman Self Employed 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Michael Myers Richards Carol Clarke 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Michael Myers Richards, Father 5907 Tilghman Island Road Tilghman, MD 21671 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 10/07/09 4 □ Donation 5 □ Other (Specify) Baltimore, Maryland 21. Signature of Funeral Service Licensee Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caused in each line. TRAYMATIC BLEFP Immediate Cause (Final **Physician** disease or condition resulting in death) SECTIFICATION APPROVED BY MEMORAL STATES /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (Linas a consequence of) Examiner the Hospital or Attending Physician: The law requires that the death certificate be execute attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Ye ar in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) I ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₽ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificate has been si rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 🗷 No 1 ☐ Yes 2/€No 25. Was case referred to medical examiner?

1 Yes 2 □ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 
Natural 5 Pending investigation LADOGER 7:15 PM FROM SCALETERBEN 30 5000 1 ☐ Yes 2 ANo 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ST. MICHAGLI 4 ☐ Homicide CREEK PORTER 1 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year)
November 4, 2009 29c. License number 29b. Signature and title of certifier FELLOW BACHMO 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ADAM SItOCK TRAVMA CONLEY R 32. Registrar's Signature 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** ALPHONSO 1:57 AM October /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner NA MANORCARE " FALLS RUAD BALTIMORE If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1⊠M 2□ F 213-30-3343 MARY SANUARY 9,1932 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State The state of 28a-f show the state of the sta 1 Yes 2 No Director IMORE BALT MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with Funeral AUCHENTORDLY 2812 Race - American Indian, Black, White, etc. of Health and Mental Hygiene. If item 27 Is marked other than "natural", or items or other traumatic event, the Medical Evan natural 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Armed Forces:
1 MYes 2 No
1f Yes, Give 1950 - 1954
Year or Dates: 1955-1961 1 ☐ Never Married 2 M Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: BLACK þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DRIVER CAB IQTH GRADE YELLOW 18. Mother's Name (First, Middle, Maiden Surname) MN - UNIKNO. つい 17. Father's Name (First, Middle, Last) Be SILLIAMS DOROTHY ည WILLIAM 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 24 ARABIAN CT., RANDALLSTOWN, MD 21133 Department of Health Important: If item 27 any injury or other tronge. ALPHONSO RIDDICK JR. (50N) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State GARRISON FOREST CEM. 10/09/2009 OWINGS MILLS, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) SOSEPH HIBROWN JR. FUNERAL HOME 2140 N. FULTON AVE., BALTIMORE, MD 21217 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month in the past 12 months? 5 Other (specify) 1 ☐Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown after death.

Director: After this certificate has been siden by the funeral director, page 2 should to by the funeral director, page 2 should to 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1□Yes a⊠No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Natural 28c. Injury at Work? 5 Pending investigation 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide in 24 hours the Funeral Dire 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

within 2 To the I

29b. Signature and title of certifier

utain

29c. License number

29d. Date signed (Month, Day, Year)

theet saltinege MD21201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 3. Time of Death 0128 M 2. Date of Death Physician/ FFITT AMES Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death **Arundel** Tate Hospice House Linthicum Anne Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country) Maryland Days (Month, Day, **January 25** Months Hours Min 215-64-3177 **Director** 57 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔀 No Maryland Anne Arundel Brooklyn 10e. Street and Number of Health and Mental Hygiene.
item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral filed within 72 hours after death with 610 Cromwell Avenue 21225 United States 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 ▼No Yes, specify Cuban, Mexican, Puerto Rican, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Insurance <u>Accounting</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Edward Reffitt Mildred Florence Ely . Page 1 and 2 should ment of Health and N lant: If item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Betty L. Rose/ Sister 610 Cromwell Avenue, Brooklyn, Maryland 21225 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State October 8 1 Burial 2 X Cremation 3 Removal from State Important: If any injury or 4 Donation 5 Other (Specify) Paltimore, Maryland Metro Crematory, Inc. 2009 Signature of Funeral Service License Allanca Heaston 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Paltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ 10 disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exam burial-transi and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical The law requires that the death certificate be Box 68760 the as IF FEMALE use yes, outcome of pregnancy

Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for L in the past 12 months?

1 Yes 2 No 5 Other (specify) Day Pregnant at time of death n signed by the a 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 Yes 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 🗌 Yes 2 🗌 No Yes 25. Was case referred to medical or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence DICE ၉ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred TUSE Natural 5 Pending 1  $\square$  Yes 2 🗌 No Investigation 6 Could not be filled in by the Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier peted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

State Registrar 31. Date filed (Month, Day, Year) 8

Name and address of person wild completed cau

3

Signature and title of certifier

only one)

29b.

A2. Registrar's Signature

of death (Item 23a) (Type, Print)

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Margaret Sweeney Rogers OCTOBER Z14. 2000 : 2021 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Saint Joseph Medical Baltimore Center Towson 8. Date of Birth (Month, Day, Yea April 23 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Year) Country Funeral Days Min 1 □ M 2 □ F 1919 90 217-05-4048 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evaninar must be notified at 1 ☐Yes 2 No Director **Timonium** MD **Baltimore** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 12201 Burn Court Rd. #404 21093 Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2 No Specify Specify: white à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed within Hygiene. Hospital n/a Administrative Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked ony injury or other traumatic ev and Mental Mary Judge Owen Sweeney ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12201 Burn Ct. Rd. #404 Timonium, MD 21093 Paul Rogers/husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 10/8/09 1 X Burial 2 ☐ Cremation 3 Removal from State Dulaney Valley Memorial Gardens Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) <sup>22. Name and Address of Facility</sup> Lemmon Funeral Home of Dulaney Valley, 10 W. Padonia Rd., Timonium, MD 21093 21. Signal of Funeral Terrice Joen Inc. Michael J. Flagle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner burial-transi and Due to (or as a consequence of) physician the burial Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) □Yes 2 No signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>م</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown ASPIRATION PNEUMONIA certificate has been s rector, page 2 should i Completed ATRIAL FIBRILLATION/ATRIAL FLUTTER 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☑No 1 □Yes 2 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner' Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1∐Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No neral Director; / 2 Accident investigation 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical

the death certificate be executed P.0. Division of Vital Records, I or Attending Patter death. Hospital 24 hours e Funeral within 2 To the the ပ

with the Maryland

within 72 hours after death

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Baltimore, Maryland 21215-0036

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie U 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 75.05 OCLER DRIVE TOWSON, MARYLAND
32. Registrar's Signature 31. Date filed (Month, Day, Year)

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20b, per Fb 8896 10/27/09 TT/ #1perPHYS 6897 11/17/09, WS

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Robert Alphonsa Nateze Stewart 2. Date of Death 3. Time of Death Year 23:03 M Ockber OY 2009 tewar 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Baltimore Johns Hopkins Bayview If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Days Hours Min. 1**X** M 2□ F Months 213-02-6762 32 PTEMBER 25,1982 MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ¥Yes 2 No MARYLAND BALTIMORE NIA 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. ASBURY STREET 4632 2120 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 X Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NIA STUDENT YEARS 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) STEWART R. ELWINA ELMIER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ELWINA E. WELLS (MOTHER) 11.37 N. MOUNT ST., BALTIMORE, MD 2121 20b. Place of Disposition (Name of Kingmetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State 5 Memorial Park 10/12/2009 BALTIM ORE, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility

OSEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licensee Illiams 2140 N. FULTON AVE, BALTIMORE, MD 21217 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final ue to (or s a consequence of). Infection - Meningits disease or condition resulting in death) Due to (or Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐Yes 2 ☐ No. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) aminer? Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide

executed P.O. Box 68760, The law requires that the death certificate be Division of Vital Records,

sician and burial-transit anding physician use as the burlal attending properties for use as signed by the a I be detached fo cate has been si page 2 should I this certificate funeral director, After death. spital or Attendi lours after death. neral Director: A within 24 hours a Hospital

Physician

/Medical

**Examiner** 

Director

Funeral

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Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

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Pages 1 and 2 should be filed within 72 hours after

n and Mental Hygiene.

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it of . : if it

**Physician** 

Examiner

/Medical

Department of Important: If any injury or once.

altimore, Maryland 21215-0036

29b. Signature and title of certified

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Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

mD mPH RES - 000

29c. License number

29d. Date signed (Month, Day, Year) October 05 2000

ddress of person who completed cause of death (Item 23a) (Type, Print)

Bollmore mar Hospital 600 North wolfe

State Registrar Date filed (Month, Day, Year)

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State of Maryland / Department of Health and Mental Hygiene

			State Registrar		Cei	rtificate of I	Death		Reg. No.	0000	300	10
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and in	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death		4c.	County of Death	1	
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	Funeral		5. Social Security Number 6. Se	THE OF I	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th y, Year)	9. Birth	nplace (State or F untry)	-oreign
	Director		Usual Residence of Decedent	X <sup>M</sup> 2 52				01 26	5 1	957	MD	
	and		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation					10d. Inside City	Limits
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	ms 2	Funeral	11. Marital Status	12. Was Decedent Ever in U.	.S. 13. 1		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	-	14. Race - Amer	ican Indian,	
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5			23a. Par 1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.			·91		,	Į.	Interval Betwe Onset and De	en ath
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<u>ita</u>	ctor,	Be (	25. Was case referred to medical examiner?				26. Place of Deat	h (Check only o	ре)			
Ž	Physician: The law requires that the death of this certificate has been signed by the attendral director, page 2 should be detached for un		1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐			4 LI Nursing Ho	ome 5⊟riesi	dence (	6 ☐ Other (Spec	cify)	
Division of Vital Records,	ing Ph After th uneral	ü	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Wor	Ŕ?	28d. Describe	how injur	y occurred		
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Ξ	or At fter d direct in by	Certification: To	4 Homicide determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, str <i>fy)</i>	eet, factory, office		28f. Location (. City or To	Street an wn, State	nd Number or Ru e)	ıral Route Numbe	∍r,
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X	To the Hospital or Attending Ph within 24 hours after death To the Funeral Director: After th completely filled in by the funeral	Me	29b. Signature and title of certifier	and mainter stated.		29c. Licens	e number		29d. Da	te signed (Month	h, Day, Year)	
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			30. Name and address of person who o	completed cause of death (Ite)	m 23a) (Tyne	Print)	13/1			-13/3	-	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		-	State Registrar		Cer	rtificate of	Death	Re	g. No.	200	The second second	
			1. Decedent's Name (First, Middle, Las	t)				Date of Death     Month	Day V	'ear	3. Time of I	
	Physicia /Medic		Linda Mary	Snow				October			8:15	Α <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give	_			r Location of Death		4c. County of			
and a			7725 Charlesmont F			Dunda If Under 1 Year		9 Date of Birth	Balti			r Foreian
	Funeral		5. Social Security Number 6. Security Number 11	ex 7. Age ( <i>In yrs. le</i> 57	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, December 1	Year) 8 1951 M		lace (State or	i oreign
н	Director		Usual Residence of Decedent	37				Table 1	OVIDOI IM	ichi	yan	
	and		10a. State 10b. County	10c. City	, Town or Lo	cation				1/	0d. Inside Cit	y Limits
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	the 1	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of Wh	at Coun	ntry?	
	3a or	Funeral Directo	7725 Chalesmont Ro	oad .			21222		US	A		
	death ms 2	ner	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H	Hispanic Origin? (Span, Mexican, Puerto	ecify Yes or No-	14. Race	Americ White, 6		
9	or ite		1 ☐ Never Married 2 🔀 Married	1 ∐Yes 2 ∭XNo If Yes, Give		1 □Yes 2 No	Specify:	Thousand area	Specify:			
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2-0	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or items 23a or 28a-f show event, the Medical Expiration 1, ast the notified at	Completed	15. Decedent's Ed (Specify only highest grades)	ucation de completed)	(Give	dent's Usual Occup kind of work done	during most of work		16b. Kind of Busi	ness/Ind	dustry	
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<u>a</u>	is is		19a. Informant's Name/Relationship (7				ont Road				21222	
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altimore, Maryland 21215-0036	Pages nent of int; If it iry or o		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		matory or other pla Crematory	:		Baltimor	e, M	Marylar	nd
Balti	permit. Pages 1 Department of H Important: If Ite any injury or ot		21. Signature of Funeral Service Licen	See De	, Ĉ	2. Name and Addre ONNELLY F	uneral Hoers Point	ome Of Du	ındalk,P	.A.	21222	
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H		0. 5	shock, or heart failure. Ust only immediate Cause (Final	one cause on each line.	h-t-	η				74.	Onset and I	Death
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Box	death certific attending p		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	I death 3	Ectopic pregnan	су		23d. Date Mon		-	Year
О.	e dea the at ied fo	Physician	in the past 12 months?	4 ☐ Pregnant at time of d 9 ☐ Unknown	death 5	Other (specify)					,	
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Division of Vital Records,	or Atte ifter dea Directo in by th	Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ome, farm, st	treet, factory, office		28f. Location (S City or Tow	treet and Numbe n, State)	r or Rur	ral Route Nur	nber,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page		29a. Certifier 1 Certifying Pl	hysician: To the best of my kno miner: On the basis of examina	owledge, dea	th occurred at the nvestigation, in my	time, date and place	e, and due to the ourred at the time, or	cause(s) and ma date and place, a	nner as	stated. to the cause(	s)
P	To the Ho within 24 To the Fo complete	Medical	one)	and manner stated.			nse number		29d. Date signed			
4	Viti Vor	2	29b. Signature and title of certifier	01 11 00.		250. LICE	Den 1 L I	'	10/1/1	4	,,,	
			m. jurel	wall litable	cian	0/7	717		10/6/0			
			30. Name and address of person who	. /	п 23а) (Туре Ц <b>4</b> Ц	D FACE	AN AVE	BALTI	more M	1	1224	
	C+	ato	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	- 10/13/20	1	3-1-11	,,			
	Pogiat	ate	UCT 0 A 2009	March. A	har	21						

			FOI	epartment of Health and N Certificate of Death	lental Hygie Reg.	0000 00001
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	Day Year 3. Time of Death
1	/Medic	al	Lynn Stricklan  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	October	06 2009 07:39 A M
1	Examin	er	2230 Evelyn Drive	Pasadena		Anne Arundel
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtl	Months   Davs   Hours   Min.	8. Date of Birth (Month, Day, Ye	9. Birthplace (State or Foreign Country)
	Director		217-40-2789 1 M 2 H 66 1	rs.	March 04	1943 MD
	yland how		10a. State 10b. County 10c. City, Town	or Location		10d. Inside City Limits
	e Mar Ba-f s	cto	Maryland Anne Arundel	Pasadena		1 ☐ Yes 2√ No
	with th	Dire	10e. Street and Number	10f. Zip Code	10g.	. Citizen of What Country?
	leath v	Funeral Directo	2230 Evelyn Drive  11. Marital Status   12. Was Decedent Ever in U.S.	21122 13. Was Decedent of Hispanic Origin? (Sp	ecify Yes or No-	USA 14. Race - American Indian,
980	72 hours after death with the Maryland natural", or items 23a or 28a-f show disal Evantinat rust be ristilled at	by	1 □ Never Married 2 □ Married 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White, etc.  Specify: White
21215-0036	vithin sne. <b>tha</b> n "	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	ing	b. Kind of Business/Industry  Jorthrup Grumman
	e filed v al Hygie l other i vent, II		17. Father's Name (First, Middle, Last)	ech. Assistant 18. Mother's Nam	e (First, Middle, Mai	
lan	should be nd Mental marked o	To Be	Clifford Darling	Vi	Hedges	
Maryland	nd 2 alth a 27 is 27 is r trau			Mailing Address (Street and Number or Ru 230 Evelyn Drive, Pa		
Baltimore,	ges 1 a It of Hea If item or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of cemeters	Disposition (Name of Act.	10	c. Location - City or Town, State
ţ	t. Pages tment of tant: If it		4 Donation 5 Other (Specify) Glen H	aven Cemetery 20	009 G1	en Burnie, Maryland
Bal	permit. Pages Department or Important: If i any injury or once.		21. Signatur of Funeral Service Licegsee	22. Name and Address of Facility 3111 Mountain Ro	-	Funeral Home, P.A. dena, MD 21122
		. 11	23a. Part i. Enter the disease, or complications that caused the death. Do n shock, or heart failure. List only one cause on each line.	ot enter the mode of dying, such as cardiac	or respiratory arrest	t, Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the content of	Cancer		2 yrs
	Examiner		Ju Par	Lonsun		Many year
t	pa ti	iner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of course Error Underlying)	n: 0		2 /
_	xecute and I-trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last c. Due to (or as a consequence of	dependence		Recent
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687	tificate ig phy as the					
Вох	ires that the death certific signed by the attending I i be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the part 12 months? 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of delivery  Month Day Year
0.	the al	/sici	in the past 12 months?  1 □ Yes 2 No 9 □ Unknown	5 Other (specify)		World Day feat
σ.	requires that the been signed by th hould be detache	/ Ph	Part II. Other significant conditions contributing to death but not resulting in	the underlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
of Vital Records,	quires an sign uld be	ed by			1 ☐ Yes	2 No 3 Probably 4 Unknown
eco		Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
E E	The ate h	Com			performe	
Vita	iclan certifi ector	Be	25. Was case referred to medical examiner?	Othor:	th (Check only one)	
of	iding Physith. In: After this funeral direction	n: To	27. Manner of Death 28a. Date of Injury 28b. T	ime of 28c. Injury at	ome 5 Residence 28d. Describe how	ce 6 Other (Specify) injury occurred
ion	Attending I ar death. rector: After by the funer	atio	2 Accident investigation	jury Work? M 1 □Yes 2 □No		
Division	al or Atte s after de al Directo	Certification: To	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
	To the Hospital or Attenwithin 24 hours after deatl To the Funeral Director:	Medical (	29a. Certifier (Check only one)  1	death occurred at the time, date and place dor investigation, in my opinion, death occu	, and due to the cau rred at the time, date	ise(s) and manner as stated. e and place, and due to the cause(s)
	Vithii Vithii Comp	Ž	29b. Signature and turn of certifier	29c. License number	10	I. Date signed (Month, Day, Year)
	4			D 00 405	/ /	0/6/01
	VV		30. Name and address of person who completed cause of death (Item 23a) ( Mirza Nusairee, M.D., 1401 Madison		urnie. MD	21061
	Sta	te	31. Date filed (Month, Day, 2009 32. Registrar's gnature)			
	Registr	ar	THE ME FARD COLORED IN 18			

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) **Examiner** uture are If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 🕱 F -22-838 -22 ary Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a. State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It will will be a single of the traumatic event, It will will be a single of the traumatic event, It will will be a single of the traumatic event, It will will be a single of the traumatic event, It will be a single of the traumatic event, It will be a single of the traumatic event, It will be a single of the traumatic event. 1 ¥es 2 No Director ha 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Departmit. Pages 1 and 2 should be filed within 72 hours after death with 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic news 21211 1/VC Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: 13/ack Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: ģ 3 ₩Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Nother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ inder 19b. Mailing Address (Street and Number or Rural Route Number, City or To Informant's Name/Relationship (Type. Print) rlton 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirator shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** e vovo resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-transit 126 Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 3 Ectopic pregnancy Month 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed 1 Yes 2 1100 certificate 1 ☐Yes within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, to the funeral director, the funeral director, the funeral director of the funeral di 26. Place of Death (Check only one) Be 25. Was case referred to medical examiner? Other: 1 ☐ Yes 2 ☐ ¥6 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27, Manner of Death 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier of death (Item 23a) (Type, Print) 30. Name and address of person who completed c RD RANDALLSTOWN MD 2113 50 OLD COUNT AD CYEMISI M.

DHMH 17 Rev 1/2001

State Registr<u>ar</u> 31. Date filed (Month, Day, Year)

ORIGINAL

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend #18 per rll G901 3/18/10 TI
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day-**Physician** October 3, 2009 9:30 A M Seiler Martha Η. /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Seasons Hospice If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min. 1 □ M 2 🖾 F Director 577-01-7003 91 March 12,1918 Washington DC Usual Residence of Decedent 10c. City, Town or Location show 10b. County 10d. Inside City Limits item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Madical Examiner rust be notified at Director 1 ☐ Yes 2 No Pikesville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 21208 8911 Reisterstown Road, #324 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 21 No Specify. ş Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 n/a Manager Gift Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be fi Be Virginia Anna Virginia Gregory Edward Wenner ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 Is James Hollister/Son 1404 Oglethorpe Dr., Suwanee, GA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Oct 5, 2009 Glen Burnie, Maryland Atlantic Crematory 21. Signature of Funeral Section See 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. Michael-J. Flagre 10 W. Padonia Road, Timonium, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one sause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final cardiovascular disease **Physician** Atheroscleratic disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician are for use as the burial-t Due to (or as a consequence of) P.O. Box 68760, Physician/Medical as yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year 4 Pregnant at time of death 5 Other (specify) signed by the a □Yes 2 No 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 Yes 2 No 3 Probably 4 Nhknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t 24a. Was an performed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 □Wo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) intration hospice Other: 4 Nursing Home 5 Residence 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 6 Other (Specify) 27. Manyer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □No after death Director: A in by the f 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Funeral Direct
To the Funeral Direct 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29h. Signature and title of certifier 29d. Date signed (Month, Day, Year) 20097 465 VISKajapaluseM.D 10/5/09. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 25 Main St. 7 Suite 200, Reisterstown, MD. 21136 S. Rajapakse, M.D. 31. Date filed (Menth, Day, Year) CCT 08 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 0420 M Loren Chase Simmons October 2009 /Medical 4c. County of Death
Baltimore 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Seasons Hospice If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 28, 1922 Washington D.C. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 1 ☑ M 2 □ F 86 578-20-7657 December Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County works item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "bedical Examiner must be realised at 1 ☐ Yes 2 X No Baltimore Director Baltimore Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21207 2617 Poplar Drive Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11, Marital Status within 72 hours after 1 X Yes 2 □ No If Yes, Give 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: ģ White 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Education Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fill and Mental F Be Frances Settle Unknown Simmons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is n any injury or other traun 75 Hampton Court, Lexington, KY Frances Renfro / Half Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Towson, Maryland Hilltop Service Corp. 10/8/2009 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Tome, Inc. of Juneral Service License 21. Signature 1050 York Road, Towson, Maryland 21204 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Metastatio **Physician** resulting in death) /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, i.a.ry, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of) Examiner attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hast autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 No 1 ☐ Yes director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 8 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ၉ After thi funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Injury 5 Pending death. investigation 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: completely filled in by the f 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 0 within 24 hours a the Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifie

State

cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) OCT 0 8 2009

3. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

OLD COURT Rd Randallstown MD

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day $A^{\,\mathsf{M}}$ 2009 <u>William Herdman Schwatka, III</u> October 0 6 4:55 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Baltimore Greater Baltimore Medical Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) September 30, Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Hours Min 1**∑**M 2□ F 64 215-44-1687 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Parkville 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Delafield Court 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 🕅 Married 1 ☑Yes 2 ☐ If Yes, Give Year or Dates: 2 □ No Specify: White 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Building Maintenance Spysr. Baltimore County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Herdman Schwatka, Jr. Alice Vee Lyons 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzanne Schwatka / Wife 10 Delafield Court, Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10/12/2009 Towson, Maryland 21. Signature Juneral Service Licentee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SQUAMOUS CELL NASAL PHARYNGEAL CARCINOMA disease or condition resulting in death) Due to (or as a consequence of): ARDIO MYOPATION Due to (or as a consequence of) ESOPHAGEAL DILATATION Due to (or as a consequence of): LIVER MG7ASTASLS 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown

**Physician** /Medical **Examiner** 

signed by the attending physician and ibe detached for use as the burial-trar

cate has been si page 2 should b

After this certificate

funeral (

completely filled in by the

Certification:

Medical

Hospital or Attending Physician;

death. after death.

1 24 hours

To the within 2

death certificate be executed

P.O. Box 68760,

Division of Vital Records,

**Physician** 

Examiner

**Funeral** 

Director

works

Directo

Completed

Be

2 should be filed within 72 hours after death with the Maryla nand Mental Hygiene. Its marked other than "natural", or items 23a or 28a-f show its marked other than "natural", or items be reafficed at reunalic event, the Medical Examinar must be reafficed at

Pages 1 and 2 should be nent of Health and Mental

Injury or other traumatic

permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 is
any Injury or other trau

 $Senu(1/\alpha)$  Millial Baltimore, Maryland 21215-0036

/Medical

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Exami by Physician/Medical 9 Unknown Completed 25. Was case referred to examiner? Be 1 Yes 2 No P

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pa	rt I.

24a. Was an autopsy perform Yes 2 No

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

					1 L Yes	2 100	1 Li Yes 2			
medical				26. Place of Death (Check only one)						
	Hospital:	2 ER/Outpatient	3 □ DOA	Other: 4 Nursing H	Home 5 ☐ Resi	idence 6	3 ☐ Other (Specify)			
	28a. Date of Injury	28b. Time of	28c.	Injury at	28d. Describe	how injury	y occurred			

28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation

28b. Time of 28c. Injury at Work? М 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

3 ☐ Suicide

4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier Cun Win Mymi

6 ☐ Could not be

determined

D0055301

29d. Date signed (Month, Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6701 NORTH CHAMES STREET

32. Registrar's Jignatur

TOWSON, 5100,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 4th SILVER LEON October 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltmore County

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth

Months | Days | Hours | Min. | 10-14-1925 68 Baltimore Sinal Hospita 5. Social Security Number 9. Birthplace (State or Foreign Sex 1 X M 2 □ F Age (In yrs. last birthday) **Funeral** 228-18-9274 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, IPs Medical Exprises must be not lifted at 1 ☐ Yes 2 No Director MD BALTIMORE BALTIMORE 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 1450 BEDFORD AVENUE, #406 21208 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 11. Marital Status Black, White, etc. be filed within 72 hours after 1 ☐ Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 X No Specify: <u>ک</u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) SALES INSTALLMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be GUSSIE MENDELSON RALPH SILVER ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) HILDA SILVER/WIFE 1450 BEDFORD AVENUE, #406, BALTIMORE, MD 21208 ਕੀਵਿਨਾ† 3altimore, l 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 🕅 Burial 2 ☐ Cremation 3 ☐ Removal from State 10-07-2009 SHAAREI ZION CONG. BALTIMORE, MD Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. Signature of Funeral Service Licenses leele 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 23a. Tart 1. Enter the disease, and implications that on sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 7days **Physician** Preumonta disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ∐ Yes 2 🙀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident filled in by the 3 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated

Division of Vital Records, P.O. Box 68760, within 24 hours after death To the Funeral Director:

> State Registrar

29b. Signature and title of certifier

Graham

31. Date filed (Month, Day, Year)

Dondlinger 30. Name and address of person who completed cruse of death (Item 23a) (Type, Print)

> MD Registrar's Signature

DHMH 17 Rev 1/2001

29c. License number

29d. Date signed (Month, Day, Year)

Baltimere

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TTEM# 22perFH, G896, 107, 8709, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. (\_ 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 12:45 am 28th 2009 Cassandra Ann Turpin Sept /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Prince George 6326 57th Ave Riverdale If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 🖫 F Director June 1 1959 DC 579-78-8383 50 Usual Residence of Decedent hours after death with the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b County ral", or items 23a or 28a-f show Examinar must be notified at 1 Yes 2 □ No Director Md Prince George Riverdale 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6326 57th Ave 20737 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 □Yes 2 □XNo Specify Completed by Specify: Black 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) filed within 72 (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker N/A 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mental I Phillip D. Turpin Sr. 1 and 2 should b Health and Ment <u>Geraldine V. Washington</u> and I 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 9635 Barrel House Rd. #J Laurel, MD 20723 Shandell Turpin/ Daughter Item 27 Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 permit. Pages Department of Important: If It any injury or o Burial 2 Cremation 3 Removal from State 10-6-09 Waldorf, MD Heritage Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Tobas Middleport Falliv Ronald what of Ling MD 29011
Tyrone J. Young 719 Kennedy St. NW WashDC Ignature Funeral Service Licensee Consult Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Metastatic Recurrent Lung Cancer disease or condition resulting in death) 10 Months /Medical Due to (or as a consequence of): Examiner Non small Cell Lung Cancer 6 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner 20 years the death certificate be executed Chronic Obstructive Lung Disease the burial-tran resulting in death) Last Due to (or as a consequence of): Box 68760. physician Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? for Month Day Vear 5 Other (specify) detached o 9 Unknown ۵. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by of Vital Records, sign 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Chronic Heavy Tobacco usage 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed 1 ☐ Yes 2 No 1 □Yes 2 No 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 XResidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☑ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred at or Attending F safter death.

I Director: After d in by the funers Division 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 24 hours a To the Hospital 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely (Check only and manner stated. within 24 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) DC 15185 September 29,2009

State Registrar

DHMH 17 Rev 1/2001

pe, Print

106

32. Registrar's Signature

Washington, DC20010

Irving St. NW POB Building, Suite #2200N

30. Name and address of person who completed cause of death (Item 23a) (T

John E. McKnight, M.D. MBA
31. Date filed (Month, Day, Year)
32. Registrar's S

OCT OR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Manth **Physician** Deptember 2009 1:10 a. M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Davs | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) Funeral 217-66-6698 Manilance Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 Jyes 2 □ No ms 23a or 28a-f s must be notified Director altimer 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Numb Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12 Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ō 1 Yes 2 16 þ 3 Widowed 4 Divorced Year or Dates "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Is marked other than "natural aumatic event, the Medical 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) turn, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LING ည 19a. Informant's Name/Relationship (Type. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an Important: If item 27 Is any injury or other trauonce. 203. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🔽 Cremation 3 ☐ Removal from State 28/09 Baltimore, MO 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Freeral Service Livens one00 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician days disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): physician ar Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Tectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 2 No 9 Unknown 9 Unknown significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 → Nknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has b 2 No 1 🗌 Yes 2 🗌 No Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner Hospital: 1 Inpatient Other: 4 Nursing Home 21 No 1 Tes 2 ER/Outpatient 3 DOA 5 Residence ٩ this Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: I Director: After to ad in by the funer 1 Natural 5 Pending investigation Injury 1 Tes 2 🗌 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 2 Accident 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide Hospital

the

0

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) - Ting PHD HO Juen9

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

State Registrar

Medical

29a. Certifier

29b. Signature and title of pertif

31. Date filed (Month, Day, Year)

Registrar's Signature

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

RES-000

			1 - State Registrar		artment of Health and rtificate of Death		ene . No. O O O O	
			Decedent's Name (First, Middle, Last)			2. Date of Death	E	3. Time of Death
	Physici /Medi		Thelma Wil	102		Month 10	Day Year <b>2009</b>	1:55p. M
- Mary	Examir		4a. Facility Name (If not institution, give street and		4b. City, Town, or Location of Deat		4c. County of Death	
			4421 Pall Mall Roa	đ	Baltimore			
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Y	9. Birth	place (State or Foreign
	Director		213-20-7337	78 Yrs.		07 22	31	MD
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation			10d. Inside City Limits
	Maryl f sho	ō	MD NA		imore			Yes 2 □ No
	the 1	Director	10e. Street and Number		10f. Zip Code	10g	. Citizen of What Cou	ntrv?
	3a ol	<u></u>	4421 Pall Mall Roa	đ	21215		U.S.A	-
	ms 2	Funeral	11. Marital Status 12. Was D	Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ameri	
215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evamir armust ke redified at	þ	1 Never Married 2 Married 1 Yes	es 2√z No	If Yes, specify Cuban, Mexican, Puert  1 □Yes 🐪 □ No Specify:	o Rican, etc.)	Black, White, Specify: B1	
5-0	72 ho natur	Completed	15. Decedent's Education (Specify only highest grade complet	16a. Dece	dent's Usual Occupation kind of work done during most of wor		b. Kind of Business/Ir	ndustry
21	ithin ne.	du		e (1-4or 5+)	DO NOT use retired)	wing		
21	led w lygier her th		12th grade na	Se	cretary		S. Gover	nment
and	be fil ad ottl even	Be	17. Father's Name (First, Middle, Last)			ne <i>(First, Middle, M</i> a. helma Ke	,	
ž	d Mel	မ	James Ross McCoy	M				
, Maryland	and 2 sl salth an 127 is r er traur		19a. Informant's Name/Relationship (Type. Print) Rowena Blake-Niece		ng Address (Street and Number or Ru Pall Mall Roa			
ore	of He fitem		20a. Method of Disposition	20b. Place of Dispo cemetery, crei	osition (Name of matory or other place)	Date 20	c. Location - City or T	own, State
Ē	mit. Page partment o cortant: If injury or		1 ☐ Burial 2 【 Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify)	On-Si	· · · · · · · · · · · · · · · · · · ·	6/09 Ba	ltimore,	Md
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.	(	21. Signatur Funeral Service Licencee		2. Name and Address of Facility  arch F/H West 300 Wabash Ave	, Baltim	ore, Md	21215
			23a. Pa 1. Enter the disease, or complications the	at caused the death. Do not ent on each line.	ter the mode of dying, such as cardiac	or respiratory arrest	t,	Approximate Interval Between
	Physician	1	Imm diate Cause (Final di ease or condition	ardiamyopat	hu		1	Onset and Death
	/Medical	1	resulting in death)	to (or as a consequence f):	,			
	Examiner	_		propary Ar	tery Disease			
	ed sit	Examine	cause. Enter Underlying Cause (Disease or injury	to (or as a consequeños of):				
Ϋ́_	xecul and I-tran	xan	that initiated events c.	to (or as a consequence of);				
90	death certificate be executed e attending physician and d for use as the burial-transit			10 (01 40 4 0011004401100 01)1				
68760,	ficate phys s the	edical	d					
Box (	eath certific attending p for use as	M/	IF FEMALE: 23b. Was decedent pregnant 23c. If yes,	outcome of pregnancy			23d. Date of deliv	(Or)
m	death atte	Physician/M	in the past 12 months?		☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
0	the cachec	hysi	9 ☐ Unknown 9 ☐ U	nknown	.,,,,,			
٠, ص	law requires that the de as been signed by the a 2 should be detached f	by P	Part II. Other significant conditions contributing to		nderlying cause given in Part I.	23e. Did tobac	cco use contribute to t	the cause of death?
ğ	w require been signations beautiful to the second to the s	pe p	Renal Failure			1 □ Yes	2 SNo 3 □ Pro	bably 4 ☐ Unknown
သို	e law requ has been je 2 should	Completed				24a. Was an	24b. Were auto	opsy findings available
č	The	E O				autopsy performed 1 ☐ Yes 2 ☑	d?   death?	ompletion of cause of
of Vital Records,	ician: Th certificate ector, pag	Bec	25. Was case referred to medical		26. Place of Dea	th (Check only one)	INO TETES	2 🗆 140
<u>&gt;</u>	nding Physician: th. : After this certifics : funeral director, p		examiner? 1 ☐ Yes 2 ► No Hospital: 1	☐ Inpatient 2 ☐ ER/Outpatier	nt 3 DOA Other: 4 Nursing H	ome 5 X Residenc	e 6 □Other (Speci	fy)
0 0	ng P	ü	27. Manner of Death 28a. Da 1 ☑ Natural 5 ☐ Pending (N	ate of Injury 28b. Time of Injury Injury	f 28c. Injury at Work?	28d. Describe how	injury occurred	
Si Si	Attending r death. ector: After by the fune	cati	2 Accident investigation		M 1 ☐ Yes 2 ☐ No			
-	- ite	Certification: To		ace of Injury - At home, farm, str iilding, etc. <i>(Specify)</i>	eet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
	pital ours a strail D		COo Contifice	Ab- b- A-d				
1	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical	(Check only 2 Medical Examiner: On the	the best of my knowledge, deatl e basis of examination and/or in anner stated.	h occurred at the time, date and place vestigation, in my opinion, death occu	e, and due to the caus irred at the time, date	se(s) and manner as and place, and due t	stated. to the cause(s)
1	o the	Mec	29b. Signature and title of certifier	annot stated.	29c. License number	29d	. Date signed (Month,	Day, Year)
	- s <del>-</del> 0		Craig Gold Ab		H 53088	00	stober 5	
				ause of death (Item 23a) (Type	Print)			1000
			30. Name and address of person who completed con 1838 Greene Tree R	ood 4135 30	Print)	ryland	21208	
	Sta Registr		31. Date filed (Month, Day, Year)	. Registrar's Signature	W			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	0.0.0	iai yiaii	C	ertificate			R	eg. No.	16	32273
	Physici	on	1. Decedent's Name (First, Mide	dle, Last)						2. Date of Deat Month	11-15	Year	3. Time of Death
	/Medic			Marie Marga	ret Wi	edef	eļd				p 29, 2009		7:05 A M
	Examir	ner	4a. Facility Name (If not instituti	on, give street and numbe	r)		4b. City, T	Town, or Locat	tion of Death		4c. County	of Death	
			5. Social Security Number	Tridelphia Mill R			If Under		rksville nder 24 Hrs.	D D-44 Bi-4b		How	
	Funeral Director			6. Sex 7. A	ige (In yrs. I	ast <i>birtnd</i> a Yrs.	Months	Days Hou		8. Date of Birth (Month, Day,	Year)	9. Birthp Coun	lace (State or Foreign try)
			220-22-9259 Usual Residence of Decedent		80					Dec 8	, 1928		MD
	aryland show		10a. State 10b. Count	у	10c. City	, Town or	Location					10	Od. Inside City Limits
	e Mai Sa-f s	cto	MD	Howard				Cla	arksville				1 ☐ Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip (	Code		1	0g. Citizen of W	/hat Coun	try?
	ath w	<u>ra</u>	13341 Triadelphia						21029			U.S.A	١.
	er de items	Funeral	11. Marital Status	12. Was Deceden Armed Forces	?_	S. 13	<ol> <li>Was Deceded</li> <li>If Yes, speci</li> </ol>	ent of Hispani ify Cuban, Me:	c Origin? (Sp xican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, inc Predical Examinar must be indified at	by F	1 ☐ Never Married 2 ☐ Ma 3 ☑ Widowed 4 ☐ Divorce	If Yes Give			1 ☐ Yes 2	No Spe	ecify:		Specify.	Whit	
21215-0036	2 hou	ted	15. Decede	nt's Education		16a. Dec	cedent's Usual	I Occupation			16b. Kind of Bu		
218	thin 7 e. an "n	Completed	(Specify only high Elementary/Secondary (0-12)	est grade completed)  College (1-4or	5+)	(Gir life	ve kind of work . DO NOT use	k done during e retired)	most of work	ing			
	ed wil ygien er th	ပ္ပ	12				Re	al Eștate	Agent		F	Real Es	tate
nd	be file d oth even	Be	17. Father's Name (First, Middle	, Last)				18. M	lother's Name	e (First, Middle, N	1aiden Surnam	9)	
<u>\</u>	should be filed within and Mental Hygiene. is marked other than aumatic event, inc. Mental Hygiene.	မ		John A. Dors	ery Sr.	1					Marie Kroi		_
Maryland	12st than 7isn traun		19a. Informant's Name/Relation							al Route Number		State, Zip	Code)
	1 and 2 Health em 27 i		Patricia Marlatt (20a, Method of Disposition	Daughter	20h PI					arksville, M	D 21029 20c. Location -	City or To	un State
Baltimore,	<b>6</b> = 1 G		1 Burial 2 ☐ Cremation		CE		position (Name rematory or oth					•	
	permit. Par Departmen Important: any injury		4 □ Donation 5 □ Other (	1		-	ouis Ceme 22. Name and			05, 2009	Cl	arksvil	le, MD
Ba	permit. Departr Importa any inju		Muladis	thewhich		243	Sla 387	ck Funera 1 Old Coli	l Home, P Imbia Pik	.A. e Ellicott Cit	v. MD 2104	3	
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Betwee shock, or heart failure. List only one cause on each line.										Interval Between
4	Physician		Immediate Cause (Final disease or condition										
-	/Medical Examiner		resulting in death)	Due to (or a	s a consequ	ence of):		-2		*			
		<u>.</u>	Sequentially list conditions,	b to (or ex	e a ecoecció	ores off-							
1	uted I Insit	min in	Sequentially list conditions, if they leading to firm ediate cause. Enter Underlying Cause (Disease or injury	\$ 200,000	e a coneaqu	or ree uny.							
Ć,	certificate be executed adding physician and ise as the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or a	s a consequ	ence of):				<u>.</u>			
68760,	ite be ysicia ie bur	cal		d									
98	ertifica ing ph	Medical	IF FEMALE:										
Вох	eath cer attendin for use		23b. Was decedent pregnant	23c. If yes, outcom	e of pregnar		B ☐ Ectopic pre	egnancy				e of delive	,
0.	re death the atter ned for u	Physician/	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant 9 ☐ Unknown	at time of de		5 ☐ Other (spe				Mor	ith	Day Year
σ.	hat th	Phy	Part II. Other significant condit	lone contributing to death	but not room	Iting in the	underbies ee	una sivan in D	le ut I	220 Did toh		ibusta da dh	e cause of death?
rds,	w requires that the d been signed by the should be detached	d by	- Tarkii Guici Sigiilicani Collan	ena contributing to death	but not resu	iting in the	undenying car	use given in F	art I.	± y ve			ably 4 Unknown
of Vital Record	law rec as bee 2 shou	Completed								24a. Was ar	24b. V	Vere autor	osy findings available
Re	0 - 0	dwo								autops: perform	ped? d	rior to con eath?	npletion of cause of
ita		0	25. Was case referred to medica	ai .				26. P	lace of Deatl	1 □ Yes 2	*	□Yes	2 □ No
<u>_</u>	ys dir	To B	examiner? 1 ☐ Yes ŽŽINo	Hospital:	ient 2 🗆 i	ER/Outpati	ent 3 🗆 DOA	Othor		me 5 Reside		er (Specify	·)
o uo	ding After funer	Certification:	27. Manner of Death  1/2 Natural 5 Pendi 2 Accident invest	28a. Date of In (Month, D	ury ay, Year)	28b. Time Injury	of 28	Bc. Injury at Work? 1 ☐ Yes		28d. Describe ho			,
Division	or Attenation after deat Director:	tifica	3 ☐ Suicide 6 ☐ Could	not be 28e. Place of Ir	jury - At hor tc. (Specify	me, farm, s				28f. Location (Str City or Town	reet and Numbe	r or Rura	Route Number,
	Hospital or 24 hours afte Funeral Dir stely filled in I		29a. Certifier Certify	ng Physician: To the bes			ath accurred a	at the time det	lo and place				
7	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	one) 2   Medica	and manner s	ot examinat	ion and/or	investigation,	in my opinion,	death occur	red at the time, da	ate and place, a	nd due to	the cause(s)
V	Vith To 1	Σ	29b. Signature and title of certific	er			29c.	License numb	per	29	d. Date signed	(Month, [	Day, Year)
			Plinx	14 WD			117	5585	29		De Diki	ub	3009
			30. Name and address of persor	who completed cause of	death (Item	23a) (Type	e, Print)	17 -	1				1.0
		20	31. Date filed (Month, Day, Year	32. Regist	rar's Signati	ure	NOUC TO	(17)	. 101	ulpi	a IV	U .	21044
	Sta Registr		OCT 082	009 Sengue	A.	40	1500						

DHMH 17 Rev 1/2001

09-07760 Betty Wilt

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day October 6, 2009 1050 hrs Medical Examiner Betty Wilt 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 905 South Curley Street If Under 1 Year | If Under 24Hrs. | 8. Date of Birth(MM/DD/YYYY) | 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 212-78-8260 Country) Maryland January 7, 1957 M 2 XF Yrs Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State s 23a or 28a-f show e notified at once. 1 XYes 2 No N/A Baltimore Maryland death with the Maryland Director 10g. Citizen of What Country 10e. Street and Number 10f. Zip Code 905 South Curley Street USA 21224 Funeral 14. Race - American Indian, Black 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc. 1 Never Married 2 Married Yes Specify: White If Yes, Give Yea Yes 2 X No specify: 4 XDivorced Widowed ğ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages I and 2 should be filed within 72 hours are tof Health and Mental Hygiene. 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) marked other than 3altimore, MD 21215-0036 Housewife Own Home 12 years 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Alexander George Kuchta Sr. Dawn Arthur Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is 1906 Snyder Avenue, Dundalk, Maryland Daughter Angela Rotondo 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition October crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 9, 2009 Halethorpe, Maryland Important: injury or oth Meadowridge Memorial Donation, 5 Other Specify <sup>22</sup> Name and Address of Facility
Connelly Funeral Home Of Dundalk, P.A
7110 Sollers Point Road, Dundalk, Md. gnat e Funeral Service 21222 Approximate Interval ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complete Physician Between Onset and failure. List only one cause on each line. /Medical Death Atherosclerotic cardiovascular disease Immediate Cause (Final disease `xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Xecii Physician/Medical AMENDED 23a, 27, permE, g896 10/15/09 TT tending physician a X UNPENDED Box 68760. 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Day Year Ectopic pregnancy Month Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown g Unknown the P.O. F 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. this certificate has been signed by I director, page 2 should be detach ş 1 Yes 2 No 3 Probably 4 V Unknown Division of Vital Records, thospital or Attending Physician: The law requires 24 hours after death. Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? Yes 2 1 1 Νo 26.Place of Death (Check only one) 25. Was case referred to medical Be Hospital: Other<sub>4</sub> Residence 6 V Other: Scene Nursing Home 5 Inpatient 2 FR/Outpatient 3 1 V Yes After t 27 Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural e Funeral Director: / Yes 2 No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number October 7, 2009 O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ling Li, MD Assistant Medical Examiner Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 6:02 A 2009 Oct. Raymond L. Wroten /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Anne Arundel Glen Burnie 7955 Queens Road Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Hours Months Days 1 1 x M 2 □ F 492-30-5160 82 Sept. 26 1927 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination mailed at 1 □Yes 2√ No Director Maryland Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7955 Queens Road USA 21061 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∏Yes 2 ☐ No If Yes, Give Year or Dates: 72 hours after 1 ☐ Never Married 2 ☑ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specity: Specity: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within 7 I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Solicitor City Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be file and Mental H Be W. Wroten Bessie Hayes John ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 st Department of Health an Important: If Item 27 is r any injury or other traur 7955 Queens Road, Glen Burnie, MD 21061 (spouse) Betty L. Wroten 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ➡ Burial 2 ☐ Cremation 3 ☐ Removal from State 09 Maryland Veterans Cem Crownsville, Maryland 2009 4 ☐ Donation 5 ☐ Other (Specity) 22. Name and Address of Facility 21. Signa re Funeral Servi Li ns Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 pplication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ron, cause on each line. 23a. Part 1. Enter the disease, or co shock, or heart failing. List onl Onset and Death Immediate Cause (Final ADENO CARO, NOTA PROSTATE Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ng physician and as the burial-tran Due to (or as a consequence of): P.O. Box 68760, certificate be Physician/Medical signed by the attending I be detached for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy The law requires that the death Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specity) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 ☐ Yes 2 ☐ Mo 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🗷 No certificate ospital or Attending Physician: Theoris after death.
Ineral Director: After this certificate by filled in by the funeral director, pa 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☐ No Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide To the Hospital o within 24 hours aff To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier OCTOBER 5 2009 236033 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NONTRO MA ROAD BBERCOULTZ 1132 ANA PROUS

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician 0700PM OCTOBER 3009 Richard D. Witz DW /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner AGNES BALTIMORE n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 M 2 □ F Yrs 66 12/13/42 Maryland **Director** 218-40-8422 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Midical Eventher must be notified at once. 10a. State 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21228 Funeral 2213 West Geipe Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a 6 Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ( Pauline\_Edwards ဂ္ Walter H. Witz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2213 West Geipe Road Catonsville, Maryland 21228 Walter H. Witz / Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Baltimore Crematory 10/8/09 22. Name and Address of Facility Loudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave. Baltimore, Maryland 21229 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List of yone cause on each line. Immediate Cause (Final disease or condition resulting in death) obstructive Physician disease DULMONUTY unknown /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) the burial-trar Due to (or as a consequence of): attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Hlnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 1 ☐ Yes 2 ☑ No 2 No 1 □Yes Vital Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this 27. Manuar of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending n 24 hours after death.

Re Funeral Director; Af olderly filled in by the fur 1 ☐ Yes 2 ☐ No investigation 2 Accident Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) within 24 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifler D47353 address of person who completed cause of death (Item 23a) (Type, Print) 30. Name an Cuton Avenue 900 Jon 31. Date filed (Month

State Registrar

DHMH 17 Rev 1/2001

32. Røgistrar's Signature

	For State	State of Marylar	nd / Department of F		tal Hygiene	
	Registrar  1. Decedent's Name (First, Midde	la Last	Certificate of		Reg. No.	3. Time of De
Physician /Medical	Barbara Hov	verton Willia		Sé	Month Day	25,2009 11:30
Examiner	4a. Facility Name (If not institution Doctors Hosp		4b. City, Town, o Lanham	r Location of Death	Pr j	ince Georges
Funeral Director	5. Social Security Number 579-568260	6. Sex 7. Age (In yrs.	last birthday) If Under 1 Year Months Days	Hours Min. 0.2	Date of Birth Month, Day, Year) -25-1942	9. Birthplace (State or F Country) PA
pu 🔻	Usual Residence of Decedent	10c Ci	ty, Town or Location			10d. Inside City I
f show		ce Georges Boy	•			1 ☐ Yes 2
vith the Mar	10e. Street and Number		10f. Zip Code		10g. Citizer	n of What Country?
th with	15107 Peart	ree Drive	20721		USA	
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.  A marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modical Evaning change to notified at To Be Completed by Finneral Director	3 ☐ Widowed 4 ☐ Divorce	If Yes Give	.S. 13. Was Decedent of In If Yes, specify Cub. 1 □ Yes 2 No	dispanic Origin? (Specify an, Mexican, Puerto Rican Specify:		. Race - American Indian, Black, White, etc. pecify: $B1$ ack
ed within 72 hou ygiene. ner than "natura t, the Medical E	15. Decede (Specify only high: Elementary/Secondary (0-12)	nt's Education est grade completed)  College (1-4or 5+)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	oation during most of working d)	10	of Business/Industry
filed with Hygien other the ent, the	·	2t	Co-Pastor			Covenant Ju
2 should be filed within and Mental Hygiene. Is marked other than aumatic event, tre Manatic event,	17. Father's Name (First, Middle  Wallace How	-		18. Mother's Name (Fir.  Jerlean		•
should to and Men and Men umartic of	19a. Informant's Name/Relation		19b. Mailing Address (Street			
1 and 2 s Health ar em 27 Is ither trau	Tammy Burton		15107 Pear			20721
permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 Is marked oth any injury or other traumatic event any Exercise Traumatic and To Be (	20a. Method of Disposition  1 Buffall 2 Cremation  4 Departion 5 Other (	3 ☐ Removal from State	Place of Disposition (Name of cemetery, crematory or other place. Grove Ceme	Date 10/03/	20c. Locat	tion - City or Town, State outh Boston,
permit. I Departm Importar any inju	21. Signature of Funeral Service		I on Name and Address		ls St. NE	20019 E Washington
ifficate be executed  B physician and as the burial-transit edical Examiner	shock, or heart failure. List immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any leading trimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Heart  Due to (or as a consequence)  c. Due to (or as a consequence)  Due to (or as a consequence)	DISEASE  uence of):  fe S  uence of):	ng, such as cardiac or res	spiratory arrest,	Approximate Interval Betwe Onset and Dea
hat the death certified by the attending letached for use as Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	d	al death 3 ☐ Ectopic pregnand death 5 ☐ Other (specify) _	·		d. Date of delivery  Month Day Yea
uires that signed d be det		one continuous great accumulation	and and an activiting cause give		1 □ Yes 2	
or Attending Physician: The law requires t after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be certification: To Be Completed by					24a. Was an autopsy performed?	24b. Were autopsy findings ave prior to completion of cause death? 1 □ Yes 2 □ No
s certification	examiner?	Hoopital	ER/Outpatient 3 □ DOA Oth	26. Place of Death (Ch	<i>seck only one)</i> 5 ☐ Residence 6 [	Tother (Specify)
nding Physith.  3. After this can funeral directors.	1 11 19 11	28a. Date of Injury	28b. Time of lnjury 28c. Injury Wor		Describe how injury o	
	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter		ome, farm, street, factory, office fy)	28f. I	ocation (Street and I City or Town, State)	Number or Rural Route Numbe
To the Hospital within 24 hours a To the Funeral I completely filled	29a. Certifier 1 Certify (Check only 2 Medica	ng Physician: To the best of my kno Examiner: On the basis of examina and manner stated.				
To the vithin To the complex complex Med	29b. Signature and title of certific		29c. Licens	se number	29d. Date s	signed (Month, Day, Year)
->-	> Gella A	(arpela)	D (	7929	9	-26-09
	ELENA M.	who completed cause of death (Iter	(Type, Print)	RO LANK	IAM MD	20706
State Registrar	31. Date filed (Month, Day, Year	32. Registrar's Signa	h hand			

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State of Maryland / Department of Health and Mental Hygiene

			1 = For State Registrar	State of Mar	ryiand	•	rtment of F tificate of I			giene Reg. No.	200	321	278
	Physici	an	Decedent's Name (First, Middle, Last	A	- 0				2. Date of Dea		Year	3. Time of D	
and.	/Medic	al	4a. Facility Name (If not institution, give	A VE	. 129		Ab City Town or	r Location of Death	0 (	(8	Year County of Deat		0 M
17.00	Examin	er	352 Derbyshire I				Riva	Location of Death			ne Arun		
	Funeral		5. Social Security Number 6. S	ex 7. Age	(In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	th		nplace (State or untry)	Foreign
	Director		224-40-6625 1 Usual Residence of Decedent	X W 20 F	73	Yrs.			Feb. 2			diana	
	yland how		10a. State 10b. County	1	10c. City, 7	Town or Loc	ation	-				10d. Inside City	Limits
	Ba-fs	Director	Maryland Anne Ar	undel		ı.	Riva					1 □Yes 2	X No
	with the	Dir	10e. Street and Number   352 Derbyshire L	ane			10f. Zip Code 2114	40		10g. Citiz	ren of What Co USA	untry?	
	death	Funeral	11. Marital Status	12. Was Decedent Ev		13. W		lispanic Origin? (Span, Mexican, Puerto	pecify Yes or No	- 1	4. Race - Ame		
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Medical Extention must be rediffed at once.	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	1957 1959	_	☐Yes 2 No	Specify:	nican, etc.)		Black, White Specify: Wh	, etc. ite	
21215-0036	72 hou 'natura	Completed by	15. Decedent's Ed (Specify only highest gra	ucation de completed)	T	16a. Deced	ent's Usual Occup	ation during most of work	kina	16b. Kin	d of Business/		
121	within ene. than "	Jdwc	Elementary/Secondary (0-12)	College (1-4or 5+)			ONOT use retired sonnel Ar	during most of work i) nalvst	9	Defe	ense De	nt	
2	filed I Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)	· · · · · · · · · · · · · · · · · · ·			John Land	18. Mother's Nam	e (First, Middle,			PC	
Vlar	uld be Menta arked atic ev	To B	Joseph H. Avery					Roxie E	. Frink				
Jar	2 sho h and r Is ma rauma		19a. Informant's Name/Relationship (					and Number or Ru			Town, State, 2	ip Code)	
e,	1 and Healti tem 27		Shirley C. Aver	y/Wife	20b. Plac	352 De	erbyshire ition (Name of atory or other plac	e Lane, R	iva, Md		L140 cation - City or	own, State	
E O	Pages nent of ant: If it		1 ☐ Burial 2 🎦 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State			atory`or other plac natory	9-21	-2009		•	Md. 21	.037
Baltimore, Maryland	permit. Departi Imports any Inj		21. Signature of Austral Service Licen	see				ss of Facility $$ $$ $$ $$ $$ $$ $$ $$	_				
			23a. Part 1. Enter the disease, or comp	lications that caused th	ne death.						ewater,	Approximate	
-	Physician		shock, or heart failure. List only of Immediate Cause (Final disease or condition			A GEY	AL CA	NCER				Interval Betwee	ath
-57	/Medical Examiner		resulting in death)	Due to (or as a									
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	bDue to or as a c	consequen	nce of):							
	cuted nd ransit	Examiner	that initiated events	C.									
60,	rificate be executed by physician and as the burial-transit	al Ex	resulting in death) Last	Due to (or as a	consequen	ice of):							
68760	= 0 m	ledical		d			5,00						
Box			IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of			Ectopic pregnance	v		2	3d. Date of del		
o	requires that the death ce been signed by the attendii hould be detached for use	Physician/N	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at ti 9 ☐ Unknown	me of deat	th 5□	Other (specify)				Month	Day Ye	ai
s, or,	w requires that the de been signed by the should be detached	by Pr	Part II. Other significant conditions of	ontributing to death but	not resultir	ng in the und	derlying cause give	en in Part I.	23e. Did to	obacco us	se contribute to	the cause of dea	ath?
ord	require een si nould t	ted							1 🗆 Y	res 2	No 3₽Pr	obably 4 ☐ Un	known
Records,	e 2 sl	Completed							24a. Was autop perfo		24b. Were au prior to death?	topsy findings av completion of cau	ailable ise of
Vital	iclan: The certificate ector, pag	ø	25. Was case referred to medical					26. Place of Deat	1 □Yes	2 <b>2</b> No		2 □No	
o   	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient	2 🗆 ER	/Outpatient	3 ☐ DOA Othe	ar.	ome 5 Resid		□Other (Spe	cify)	
o C	inding Physician: th. After this certification of the control of t	ion:	27. Manner of Death  1. Natural 5 □ Pending	28a. Date of Injury (Month, Day, )	Year) 28	b. Time of Injury	28c. Injury Work	(?	28d. Describe h	now injury	occurred		
DIVISION	the the	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury	- At home	, farm, stree		Yes 2□No	28f, Location (S	Street and	i Number or Ru	ral Route Numbe	9r,
בֿ	ital or urs afte ral Dir lled in	Cert		building, etc.					City or Tow				
	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical	29a. Certifier	/siclan: To the best of iner: On the basis of each manner state	xamination	edge, death n and/or inve	occurred at the tire stigation, in my o	me, date and place pinion, death occu	, and due to the rred at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	200	A		29c. License	number		( Carrier	signed (Monti		
•	1		PVWJ	NY	$\sim$	14		V143.	8	Jey.	Hernt	1000 MB	009
	10 W		30. Name and address of person who	ompleted cause of dear	th (Item 23	sa) (Type, P	not) DEFI	E NSE	MGH	WAy	ANNI	POLO MI	12144
	Sta Registra		SEP 2 2 2009	2. Registrar's	s Signature	par	~						

par

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 806 2009 September JANET LOUISE AUMAN 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Memorial -aston If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours Months 1 □ M 2 🕱 F 62 06/20/1947 IDAHO 519-52-7086 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State Yes 2 No TALBOT EASTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 29529 GOLTON DRIVE 21601 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ∏Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 No Specify: WHITE Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) THORTON ROSS MOXLEY MARGARET M. CARROLL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 COLONIAL COURT, EASTON, MD HARRY AUMAN/HUSBAND 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 🔀 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) WOODLAWN MEMORIAL PK 09/28/2009 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A. 200 SOUTH HARRISON STREET, EASTON, MD 21601

**Physician** /Medical **Examiner** 

requires that the death certificate be executed

Hospital or Attending Physician:

To the lawithin 2.

Division of Vital Records, P.O. Box 68760,

**Physician** 

/Medical

Director

Funeral

þ

Completed

Be

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MD

Examiner

**Funeral** 

Director

Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ita Medical Exercities must be notified at

Baltimore, Maryland 21215-0036

Janet

Examine burial-tra Physician/Medical Be Completed by page 2 s Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

23a. Part 1. Enter the disease, or comp shock, or heart failure. List only	olications that caused the death. Do not enter the mode of dying, such as cardiac or respirato one cause on each line.	Interval Between Onset and Death						
Immediate Cause (Final disease or condition	a Anoxic Encephalo	Oliset and Death						
resulting in death)	Due to (or as a consequence of):	2						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):	110-6						
Cause (Disease or injury that initiated events resulting in death) Last	c							
	s d							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   Month   Month								
	on the discountry in the discountry in a data of the discountry in	Did tobacco use contribute to the cause of death?  I □ Yes 2 □ No 3 □ Probably □ □ now						
		Was an autopsy available prior to completion of cause of death? es 2 No 1 □ Yes 2 No						
25. Was case referred to medical	26. Place of Death (Check o	nly one)						
examiner? 1 ☐ Yes 2 ☐ No	———————————————————————————————————————	Residence 6 Other (Specify)						
27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year) Injury Work?"  Injury Nork?"  Injury Nork?"  Injury Nork?"	ribe how injury occurred						
3 Suicide 6 Could not b 4 Homicide determined	1 28e. Place of Injury - At nome, farm, street, factory, office 1 201, Locati	on (Street and Number or Rural Route Number, r Town, State)						
29a. Certifier 1 Certifying Pr (Check only one) 2 Medical Exam	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to niner: On the basis of examination and/or investigation, in my opinion, death occurred at the tandard manner stated.	the cause(s) and manner as stated. ime, date and place, and due to the cause(s)						

State Registrar

DHMH 17 Rev 1/2001

Medical

31. Date filed (Month, Day, Year) **SFP 23** 

29b. Signature and title of certifier

pegistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

		1	For Amend Items 10e State of Maryland / Dep State Registrar & 19b WCHD/SH 9/30/09 per FHC6	ertificate of Death	Reg. N	
	Physicia	n/	1. Decedent's Name (First, Middle, Last)		2. Date of Death	Day 2 Year 3. Time of Death A
	Medic	al	Patsy Irene BARNHART  4a. Facility Name (if not institution, give street and number)	41- O'th Town and protion of Dooth	4	25, 2509 0900 M
	Examin	er	Washington County Hospital	4b. City, Town, or Location of Death  **Hagerstown**	,	Washington
- N.	Funeral Director		5. Social Security Number  219-82-9744  6. Sex 1	· ·	8. Date of Birth (Month, Day, Year Sept. 23,	9. Birthplace (State or Foreign
			Usual Residence of Decedent		Depo: 20;	
	yland -f sho ed at	ctor	10a. State10b. County10c. City, Town or IMarylandWashingtonClea			10d. Inside City Limits 1 □ Yes 2 ♥ No
	ne Mai or 28a notifi	Dire	10e. Street and Number 12923 Saint Paul Road	r Spring	10g.	Citizen of What Country?
	with the 23a c	Funeral Director	12923 Sample Road	21722		USA
	death items ner mi		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	B. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - American Indian, Black, White, etc.
Maryland 21215-0036	ould be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	ed by	1 ☐ Never Married 2 22 Married 1 ☐ Yes 2 22 No If Yes, Give Year or Dates.	1 ☐ Yes 2 20 No Specify:		Specify: white
5-0	72 hou "natu edica	Completed	(Specify only highest grade completed) (Given	cedent's Usual Occupation re kind of work done during most of work DO NOT use retired)	ing 16b	. Kind of Business Industry
7	/ithin 7	Con	Elementary/Seconday (0-12) College (1-4 or 5+)	homemaker		her own home
g	filed val Hyg	Be c	17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	en Surname)
Зa	uld be fil Mental narked natic ev	입	Ira Moats Sr.	Mary 923 Saint Paul Road illing Address (Street and Number or Run	<i>Younker</i> d. Clearsp	ring, MD 21722
Mai	1 and 2 should be if Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Type, Print)   19b. Ma   Kenneth E. Barnhart, SR.—husband <del>I</del>	illing Address (Street and Number or Run 2 <i>923 Samo Le Road</i> . (		or Town, State, Zip Code) ng, Mary Land 21722
	f Heal f Heal item 2		20a. Method of Disposition 20b. Place of Dis	position (Name of		. Location - City or Town, State
E C			12 Burial 2 □ Cremation 3 □ Removal from State cemetery, c 4 □ Donation 5 □ Other (Specify) Cedar I	rematory or other place) www.mawn.mem.park 9/2	9/09 Ha	gerstown, Maryland
Baltimore,	permit. Page Department of Important: If any injury or once.			22. Name and Address of Facility Management 415 E. Wilson Blvd	INNICH FUN	
			23a, Part 1, Enter the disease, or complications that caused the death. Do not e			Approximate Interval Between
	Pnysician/		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition	is of Recornet inc	ercerched	
المصيدا	Medical Examiner		resulting in death)  a.  Due to (or as a consequence of):	•		hernia
	sit sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury			
	icate be executed physician and s the burial-transit		that initiated events resulting in death) Last C. Due to (or as a consequence of):			
760	ate be ohysici the bu	edical	d			
Box 687	tth certif ttending or use a	Physician/Me	F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	B		23d. Date of delivery Month Day Year
P.O.	es that the des signed by the a i be detached i		Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.	23e. Did tobacc	to use contribute to the cause of death?
ds,	requires been sig should b	ted	Part II. Other significant conditions contributing to death but not resulting in the	i pead she some to id	1 \( \text{Yes}	2 No 3 Probably 4 Unknown
Division of Vital Records, P.O. Box	he law re ite has be bage 2 sh	Completed by			24a. Was an autopsy performed	24b. Were autopsy findings available prior to completion of cause of death?  1 Yes 2 No
tal	cian: T ertifice ector, p	Be	25. Was case referred to medical examiner?	26. Place of Death (Chec	ck only one)	
Ž	Physic this or	မ	1 Yes 2 No No Independent 2 ER/Outpa 27. Manner of Death 28a. Date of injury 28b. Time		ome 5 Residence	6 Other (Specify)
0 0	th. : After e funer	cate	1 Natural 5 ☐ Pending (Month, Day, Year) injur 2 ☐ Accident Investigation		Zod. Describe now ii	ijury document
ivisio	I or Attendi after death Director: A d in by the fu	Certificate:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rural Route Number, ate)
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has redmined filled in by the funeral director, page 2	Medical	29a. Certifier (Check only one)  29a Certifying Physician: To the best of my knowledge, deal of the best of my knowledge of the best of my kno	vestigation, in my opinion, death occurred a	at the time, date and pla	ace, and due to the cause(s) and manner stated.
	Jour Withi		29b. Signature and title of certifier	29c. License number		Date signed (Month, Day, Year)
P	134		PKI KRY	738764		9/29/04
	5		30. Name and address of person who completed cause of death (Item 23a) (Typ		127 Hec	12471 MM - 21742
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 2000 32. Pegistrar's Signature	bare		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1507 0900 GERMEK ATRICIA NN 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Ye Mar. 16, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days 1 □ M 2 🗷 F Indiana 1935 311-32-9121 74 Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City, Town or Location 10a State YYes 2 No Prince George's Bowie MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20715 USA 12422 Seabury Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No IfYes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married 1 □Yes 2XINo Specify White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Hospital Pharmacist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Catherine Federoc George Lawrence Germek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Bowie, MD 20715 Alfred C. Boyd, Jr. / spouse 12422 Seabury Lane Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 9/21/2009 Bayview Crematory 4 ☐ Donation S☐Other (Specify) 21. Signature of Funeral Survice License 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, e cause on each line. Approximate Interval Between Opset and Death 23a. Part 1. Enter the disease, or co shock, or heart failure. List of (10 Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes

Physician /Medical Examiner

requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

or Attending

death.

within 24 hours a To the Funeral C

**Physician** 

/Medical

Examiner

Funeral Director

Completed by

Be

P

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It. Modes Experience.

Examine Physician/Medical þ

physician als the burial-t attending p use as the detached signed by t Completed page 2 should certificate has funeral director, Be After this ဥ Certification: 4 hours after death. filled in by the

24a. Was an autopsy performed? 2 🗆 No 1 ☐ Yes 26. Place of Death (Check only one)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death? 2 🗆 No 1 TYes

examiner? 1 ☐ Yes	
07 Mannor of	Dooth

25. Was case referred to medical

Natural

2 Accident

3 Suicide

4 ☐ Homicide

5 Pending investigation

6 Could not be determined

Hospital: 2 ER/Outpatient 3 DOA 1 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Name and address of pera

who on pleted cause of death (Item 23a) (Type, Print) DEYENSE W1441

31. Date filed (Month, Da

Registrar's Signature

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #14.per INF, 2930 8-6-12 sm
State of Maryland Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** Butter 9:30 A M Edward 2009 JAMES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner George State or Foreign Prince trmstron-If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace Country) **Funeral** Days Hours Min. Months 1**½** M 2□ F 89 9-24-1919 Maryland Director 218-16-2021 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show th and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, it s Musical Expressions. Trust by notified at 1 Yes 2 □ No Director Upper Marlboro Maryland Prince George 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any Injury or other traumatic event, the Mudical Experience outs being once. Funeral 9107 Armstrong Lane 20772 USA Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Native American Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: Ş 3 XWidowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Foreman WSSC 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Butler ၉ Elizabeth Harley Thomas Ε. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Patricia Butler/Daughter 4200 Ryon Rd, Upper Marlboro Maryland 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Resurrection 9/26/2009 Clinton, MD 22. Name and Address of Facility 21. Signature of Funeral Service License 191 Adams Funeral Home PA, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) disease 10 years • Physician COVOMAVY /Medical ue to (or as a consequence of) **Examiner** perleusion Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last l'intardio Myoradu Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 1 □Yes 2 No 24 hours after death.

Funeral Director: After this certific etely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier, 2 Name and address of person who completed cause of death (Item 23a) (Type, Print) Alain G. Champaloup Upper Marilboro MID Mb. 31. Date filed (Month, Day, Year) SEP 2 4 2009 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

			for State Registrar	State	of Marylan		rtment of H tificate of l		and Menta		ene ı. No.	109	32283
			Decedent's Name (First, Middle	, Last)					2. Date Mor	e of Death	Day	Year	3. Time of Death
	Physicia /Medic			1	Mattie E	Broom			Sept	tembe	r 22	2009	12:30p M
	Examin	er	4a. Facility Name (If not institution		number)		4b. City, Town, or				4c. County		. 1
- 1 <sup>-28</sup>	Funeral	•	Citizens Nursin 5. Social Security Number	ng Home  6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	erick	24 Hrs. 8 Date	e of Birth		reden  9. Birthp	lace (State or Foreign
	Director		218-40-8313	1□M 2፟XF	97	Yrs.	Months Days	Hours	Min. (Mo May	nth, Day, Y	1912	Nort	h Carolina
	and w		Usual Residence of Decedent  10a. State 10b. County		10c Cit	y, Town or Lo	cation					1	0d. Inside City Limits
	Maryla f sho	tor		<b>.</b> . 1.									1 ☐ Yes 2X No
	r 28a	Directo	Maryland     Frederick       10e. Street and Number     10f. Zip Code       10g. Citizen of What Country?							itry?			
	th with		10203 Old Liberty Road								Unite	d Sta	tes
	items	Funeral	11. Marital Status	Armed		S. 13. \	Was Decedent of H f Yes, specify Cuba	ispanic Orig an, Mexican	gin? (Specify Ye: n, Puerto Rican, e	s or No- etc.)		ce - Americ ck, White, e	
36	irs aft	by F	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	If Yes, O	s 2 🔀 No Give Dates:	1	l∐Yes 2⊈No	Specify:			Specify	y: Wh	ite
5-0036	be filed within 72 hours after death with the Maryland that lygiene.  d ofthey than "natural", or items 23a or 28a-f show event, the Madical Exercitival nast be redfled at	Completed	15. Decedent (Specify only highes	's Education	d)	16a. Deced	tent's Usual Occup	ation	t of working	16	6b. Kind of B		
2	rithin 7 ne. han "r	mple	Elementary/Secondary (0-12)	<del>-</del>	(1-4or 5+)	life. L	kind of work done o		or working		0	Homo	
2	filed within Hygiene. <b>xther than</b> '		7 17. Father's Name (First, Middle, I	Last)			Homemal		er's Name (First,	Middle, Ma		Home	
<u>a</u>	wuld be i Mental arked o atic eve	To Be	John Ammons					Martl	ha Heato	on			
Maryland	should and Mer is marke aumatic	-	19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mailin	g Address (Street	and Numbe	er or Rural Route	Number, (	City or Town,	, State, Zip	Code)
	s 1 and 2 should be of Health and Menta item 27 is marked other traumatic ev		James Broom /	son			Old Lib				ck, Ma		
altimore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		mistate i		sition (Name of natory or other place		Date			,	
			4 ☐ Donation 5 ☐ Other (Sp. 21. Signature of uneral Service)	-	Pi	/ 22	ve Cemete	ss of Facilit	v			:у, Ма	aryland
Ba	permit. Departr Importa any inja		Doll !	1/1/1/	mer	St	auffer F	unerai	1 Homes	P. A. Frede	erick.	Mary	1and21702
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications tha	t caused the deat	h. Do not ent	er the mode of dyir	ng, such as	cardiac or respir	ratory arres	st,		Approximate Interval Between
	Physician /Medical Examiner		Immediate Cause (Final disease or condition August 1044)								Onset and Death		
			resulting in death)  (or as a consequence of):										
		ē	Sequentially list conditions, if any, leading to immediate b.  Dus to (or as a consequence of).										
	cuted nd ransit	Examiner	If any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.										
Ö,	icate be executed physician and the burial-transit		resulting in death) Last	Due t	to (or as a conseq	uence of):							
98760	physic the b	edical		d									
Box	eath certific attending p	n/Me	IF FEMALE: 23b. Was decedent pregnant		outcome of pregna						23d. Da	ate of delive	ery
Ď.	death	sicia	in the past 12 menths? 1 ∐Yes 2 No		re birth 2 ☐ Feta egnant at time of o		☐ Ectopic pregnanc ☐ Other (specify) _	:У 			Me	onth	Day Year
<u>Ч</u>	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/M	9 ☐ Unknown  Part II. Other significant condition			ulting in the u	nderlying souns giv	on in Part I	23	e Did toba	acco use con	ntribute to t	he cause of death?
ds,	signe	β	Fait II. Other significant conduct	ins contributing to	deall but not les	utiling in the di	idenying cause giv	en in raici.	.   20	1 ☐ Yes	1		bably 4 ☐ Unknown
Vital Records,	w requir been s should	Completed								a. Was an	24b.	Were auto	opsy findings available
æ	The la	ошо								autopsy performed Yes 2	ed?	prior to co death? 1 ☐ Yes	empletion of cause of
<u>=</u>	<b>hyslcian:</b> The law his certificate has b I director, page 2 s	BeC	25. Was case referred to medical examiner?						of Death (Chec				-74,10
<u> </u>	Physic rthis or ral dire	မှ	1 ☐ Yes 2 No		☐ Inpatient 2 ☐	ER/Outpatier		4 LV NL	rsing Home 5				fy)
U O	iding f th. After funer	Certification:	27. Manner of Death  Tal Natural 5 ☐ Pending  Accident investig	g (M	onth, Day, Year)	Injury	Worl	yai k?  Yes 2		escribe now	v injury occur	reu	
Division of	Attendi er death. ector: A by the fu	ifica	3 ☐ Suicide 6 ☐ Could r 4 ☐ Homicide determ	not be 28e. Pla	ice of Injury - At he	ome, farm, str	eet, factory, office		28f. Loc	cation (Stre	et and Numi	ber or Run	al Route Number,
	ital or irs afte al Dir led in	Cert											
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director; to	Medical	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 20 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 21 edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	To the within 2 To the comple	Mec	29b. Signature and little of certifier		armer stated.	$\overline{}$	29c. Licens	e number		29	d. Date signe	ed (Month)	Day, Year)
	F > F 0		> X All	Ya	ufores	$\sim$	mo I	)-/3	3971		9/2	3/1	29
	2		30. Name and address of person	. (	1	, ,	P <del>ri</del> ht)				- 1	1-	
	Ø.		Robert Kaufman	MD 300 V	West 9th	Street	t, Freder	ick,	Marylan	d 21	701		

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 1153 AM September 20, 2009 Broadway FILA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Memorial Easton albot Hospital @ Laston 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 F 263-62-9820 0 45-1926 Director Usual Residence of Decedent 10d, Inside City Limits 10b. County 10c. City, Town or Location 28a-f show d other than "natural", or items 23a or 28a-f shovevent, the Medical Evaniner must be notified at 1 Yes 2 No Director Ma. Of. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21660 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ∐Yes 2. No altimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2. No Specify: 3. Widowed 4 Divorced Black 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Own home tome Maker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be traumatic ည .e.tha Doughte 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau
once. Jeannette Breckenridge Haylock N.C. 28532 reek Ln. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09-26-09 Hillsboro md. 5 ☐ Other (Specify) 22. Name and Address of Facility Bennie Smith Funeral Home 21. Signature 426 Dover Street, Baston, Md. 21601 23a. Part1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastati **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner lato1 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physician and for use as the burial-transi Due to (or as a consequence of): P.O. Box 68760, Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 🗆 Ectopic pregnancy Month Year 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death, but not, resulting in the underlying cause given in Part I. of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been si ; page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed' 1 ☐Yes 2 ☐ No 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 ★ atural 2 Accident 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29b. Signature and title of certifier

State

21 31. Date filed (Month, Day, Year) SEP 21 2009

30. Name and address of person who completed cause of death (Jefn 23a) (Type, Print)

32 Registrar's Signature

Nals

Registrar

m

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Time of Death September 21, 2009 **Physician** 10:55 PM Michael Dennis Blom /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Montgomery 5100 Saratoga Avenue Bethesda 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month. Days Birthplace (State or Foreign Country) Social Security Number 6 Sex **Funeral** Days 11X M 2□ F Director Aug 24, 1954 Washington DC <u>219-64-8215</u> Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be multised at 1 TYes 2 No Director Bethesda MD Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20816 USA 5100 Saratoga Avenue by Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. filed within 72 hours after 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Master Musician Music/Entertainment 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Grace Rita Gemmellaro Louis David Blom Ith and Ment 27 Is marked traumatice ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important; If item 27 Is any injury or other trau once. 5100 Saratoga Avenue Bethesda, MD 20816 Tera Kathleen Gorman/wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Final Journey Crematory 09/24/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lie Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 3 years a. Non-Hodgkins Lymphoma disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): sician and burial-transit be executed Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical E FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Year ed by the a 5 Other (specify) P.0. 1 □Yes 2 □No 9 ☐ Unknown signed by the sign of the sign Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate has page 2 s autopsy performed? Yes 2 No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation burs after death.

neral Director: A
filled in by the ft. 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide ö To the Hospital o within 24 hours af To the Funeral Di completely filled in 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medica/Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical only and manner stated 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) September 22, 2009 D41133 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 22

> State Registrar

Daniel Fowler,

M.D.

NIH

gistrar's Signature

10 Center Drive Bethesda, MD 20892

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar Ce	rtificate of Death		Reg. No. 200	9 32286				
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Dea		3. Time of Death				
Physician /Medical			Mary Isabel Bowles			per 28, 200					
	Examin	er	4a. Facility Name (If not institution, give street and number) St. Mary's Nursing Center	4b. City, Town, or Location of I Leonardtown	Death	4c. County of Dea					
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday,	If Under 1 Year   If Under 24			rthplace (State or Foreign ountry)				
	Director		578-18-0262 1□ M 2☒F 91 Yrs.	Months Days Hours	Min. (Month, Day 05/16/1	918 Ma	ryland				
	/land		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location         10d. Inside City Limits								
	a-f sh	ctor	Maryland St. Mary's Leonardtown								
	or 28	Director	10e. Street and Number	10f. Zip Code		10g. Citizen of What Co	ountry?				
	sath w	Funeral	21585 Peabody Street  11. Marital Status 12. Was Decedent Ever in U.S. 13.	20650		United Sta					
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any highry or other traumatic event, if a Medical Extra ultra must be notified at once.	by Fun	11. Marital Status  1 □ Never Married 2 □ Married  3 □ ▼Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 □ ▼No  If Yes, Give  Year or Dates:	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, F  1 □ Yes 2 ☒ No Specify:	Puerto Rican, etc.)	Specify:	te, etc.				
9-10	2 hou latura ical E	ted	15. Decedent's Education 16a, Dece	edent's Usual Occupation		16b. Kind of Business	hite /Industry				
215	ithin 7 ne. nan "n	Completed	Elementary/Secondary (U-12)   College (1-4or 5+)	e kind of work done during most of DO NOT use retired)	f working						
121	lled will Hygier her th	So	12 Homem  17. Father's Name (First, Middle, Last)		Name (First, Middle,	Own Home					
and	d be f ental } ked ol c eve	To Be	William Alfred Johnson			maiden Surname)					
ary	2 should be n and Mental is marked of raumatic ev	Ĕ		ing Address (Street and Number of	Johnson or Rural Route Numbe	er, City or Town, State,	Zip Code)				
Z,	and 2 ealth a n 27 is		John R. Bowles, Jr./Son 1165	East Wood Landi	ng Road, S	Sunset Beac	h, NC 28468				
altimore, Maryland 21215-0036	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition 1 IX Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition Cemetery, cre	osition (Name of matory or other place)	Date	20c. Location - City or	Town, State				
Ħ.	iit. Pa artmer artant: injury		4 □ Donation 5 □ Other (Specify) / Queen of	Peace Cem. 10	/02/2009	Helen, Mar	yland				
Ba	Depril		Kyle S. Simons M01206	2. Name and Address of Facility 2.2955 Hollywood	Rd., Leona	rdtown, MD	20650				
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, ruch as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Physician disease or condition resulting in death)  a. The mediate Cause (Final disease or condition as the mediate Cause (Final disease).							Approximate Interval Between Onset and Death				
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):								
		ē	Sequentially list conditions, If the leading to his redistrictions to his redistrictions to his redistrictions.		<u> </u>						
	cuted nd ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events			V					
ő,	oe exe cian ar urial-t		resulting in death) Last  Due to (or as a consequence of):								
68760,	rtificate be executed ng physician and as the burial-transit	Medical	d		<del></del>						
o S	n certif		IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of de	alivery				
.O.	The law requires that the death ce atendinate has been signed by the attendinage 2 should be detached for use	Physician/	in the past 12 months? 1 Live birth 2 Li Fetal death 31	☐ Ectopic pregnancy ☐ Other (specify)		Month					
s, G.	res that signed b	by PI	Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did to	bbacco use contribute t	o the cause of death?				
							2 No 3 Probably 4 Unknown				
Sec.	has b	Completed	Coronary Awary E.		24a. Was a autop:	sy prior to	utopsy findings available completion of cause of				
ā	sician: The law certificate has b irector, page 2 s		OF War and a section of the section		perför 1 □ Yes	2 ■ No 1 □ Ye:	s 2 No				
>	ysicia s cert directo	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No   Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other:	Death (Check only or	*					
2	ding Phys h. After this funeral dir	on: To	27. Manner of Death 28a. Date of Injury 28b. Time of	-	Home 5 ☐ Residence 6 ☐ Other (Specify)  28d. Describe how injury occurred						
Sio	Attendir death. ctor; Ai y the fu	catic	2 Accident investigation								
Division of Vital Records,	the Hospital or Attending Physician: in 44 hours after death. the Funeral Director: After this certifical inpletely filled in by the funeral director, p	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, stream building, etc. (Specify)	28f. Location (S City or Tow	28f. Location (Street and Number or Rural Route Number, City or Town, State)						
	To the Hospi within 24 hou To the Funer completely fill	Medical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner styled.								
	Vith To t	29d. Date signed (Mon.	th, Day, Year)								
			30. Name and address of person who completed cause of death (Item 23a) (Type,	,		VV	•				
	Sta	0	James P. Jarboe, M.D. 24035 Three No. 31 Date filed (Month, Del., Year) 34 Pegistrar's Signature	otch Road, Holly	wood, MD	20636	-				
	Sta Registra	e	31. Date filed (Month, Dal, Year) 2009 32 (legistrar's Signature	. 41							

Box 68760 P.0. Division of Vital Records, To the Hospital or Attending within 24 hours after death. To the Funeral Director: After

Medical State Registrar DHMH 17 Rev 1/2001

(Check only one)

29b. Signature and

6, 31. Date filed (Month, Day, Year) 32. Registrar's Signature

and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year,

Please Type or Brint in Black Indalible Ink4 Figsure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death SEPT. **Physician** PATRICIA BAMFORD 2009 8:20  $P^{M}$ /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 45 SEAFARER LANE BERLIN WORCESTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months 1□M 2**X** F 68 **Director** 578-52-0993 24, 1940 D.C. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, The Medical Examination ust be motified at 1 ☐ Yes 2 No MARYLAND WORCESTER Director BERLIN 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 45 SEAFARER LANE 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: WHITE \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If Item 27 is marked other that any injury or other traumatic event. 11 ARTIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LAWRENCE O'CONNOR MARY SWEENEY ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J.ROSS BAMFORD/HUSBAND 45 SEAFARER LANE, BERLIN, MARYLAND 21811 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🎖 Cremation 3 ☐ Removal from State CREMATORY OF DELMARVA 9/9/09 DELMAR, DELAWARE 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MEDATAMA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (cras a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 1 ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 ☐Yes 2 ☐ No 2. No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Desidence 6 ☐ Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Aftert 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical

Maryland 21215-0036

altimore.

requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital

or Attending Division

> State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

(Check only one)

29b Signature and title of certifier

32 Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

# Physicia /Medica Examine Funeral Director and 2 should be filed within 72 hours after death with the Maryland eaith and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f show fer traumatic event, the Wedical Examinating to a cultified at , Maryland 21215-0036

Baltimore	permit. Pages 1 and Department of He Important: If item any injury or oth once.		20a. Method of Disposition  1	(y)	20b. Place of Demetery, Atlant:		ne of ther place) atory d Address of Fa ty Fune:	09/22 acility		•
8760,	ciae be executed / Medical Examiner whysician and prial-transit the burial-transit	Physician/Medical Examiner	23a. Part 1. Enter the disease, or compshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a construction of the constru	consequence of	Case Lete	e of dying, such	as cardiac of	cor respiratory a	SS.
ecords, P.O. Box 68760,	Physician: The law requires that the death certificate be executed this certificate has been signed by the attending physician and ral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  Part II. Other significant conditions of	23c. If yes, outcome of 1  Live birth 2  4  Pregnant at t 9  Unknown contributing to death but	Fetal death ime of death	3 ☐ Ectopic p 5 ☐ Other (sp he underlying c	pecify)	art I.	23e. Did 1	Ye s an
Division of Vital Records,	or Attending after death. Director: After in by the funer	Certification: To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manufer of Death  1 Natural 5 Pending investigation 3  Suicide 6 Could not be determined	28a. Date of Injury (Month, Day, e 28e. Place of Injur, building, etc.	Year) Inj y - At home, farn (Specify)	me of 2 ury M Mn, street, factory	OA Other: 4 28c. Injury at Work? 1 Yes 2	Nursing Ho	perf. 1 □ Yes h (Check only me 5 □ Res 28d. Describe 28f. Location City or To	one side ho
	To the Hospital within 24 hours a To the Funeral completely filled	Medical	29a. Certifier 1 ☑ Certifying Pt (Check only one) 2 ☐ Medical Exar	nysician: To the best of miner: On the basis of and manner state	examination and	or investigation	at the time, date, in my opinion, c. License numb	death occur	and due to the red at the time	e ca

	State of Maryland / Dep	ertment of Health and I ertificate of Death			0 00000
	Registrar  1. Decedent's Name (First, Middle, Last)	Tillicale of Dealif	2. Date of Death	. No. 1. 4.	3. Time of Death
I	Gerald T. Callaghan		Month	r 19,2009	2240 M
	4a. Facility Name (If not institution, give street and number) Anne Arundel Medical Center	4b. City, Town, or Location of Death Annapolis		4c. County of Dea Anne Arun	
	5. Social Security Number  6. Sex 7. Age (In yrs. last birthday)  1 XM 2 F 57 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, )	(ear) 9. Bir	thplace (State or Foreign ountry)
	Usual Residence of Decedent		10/10/		
	10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
3	MD Anne Arundel Annapoli	is			1 X Yes 2 No
	10e. Street and Number 681 Genessee Street	10f. Zip Code	10g	J. Citizen of What Co	•
<u> </u>		21401	necify Ves or No-	US 14. Race - Ame	
5	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give	. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:	o Rican, etc.)	Black, Whit	e, etc.
completed by runeral billector	3 Widowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. Dec	edent's Usual Occupation	16	Sb. Kind of Business	
	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of wor DO NOT use retired)			
5	17. Father's Name (First, Middle, Last)	reasury Dep't	ne (First, Middle, Ma	overnment	
3	Thomas F. Callaghan		A. Mullan		
-	19a. Informant's Name/Relationship (Type. Print) 19b. Mai	ling Address (Street and Number or Ru			Zip Code)
	Bertha-Marie Callaghan Spouse 681	Genessee St. Anna	polis,MD	21401	
	20a. Method of Disposition  1 Burial 2 Cremation 3 Removal from State	position (Name of ematory or other place)		c. Location - City or	Town, State
	4 □ Donation 5 □ Other (Specify) ATIANTIC	Crematory 09/2	2/09	Glen Burn	ie,MD
		22. Name and Address of Facility [ardesty Funeral He	ome P.A.	12 Ridgel Annapolis	yMDv21401
	23a. Part 1. Enter the disease, or complications that caused the death. Do not el shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	CARDINOL Six	sicto	W	Onset and Death
	Due to (or as a consequence of):	Astens 12500	6		3 (1101)
5	Sequentially list conditions, if any, leading to immediate b.  Due to (or as a consequence of):	The state of the s			- good
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c. c.				
2	resulting in death) Last Due to (or as a consequence of):				
5 I	d				
7	IF FEMALE: 23b. Was decedent pregnant in the part 12 months?  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3	☐ Ectopic pregnancy		23d. Date of de	
ny sicial givic		Other (specify)		Month	Day Year
-	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute t	o the cause of death?
3	Herpertacren		1 ☐ Yes	2  No 3 F	robably 4 Unknown
completed by			24a. Was an autopsy performe	24b. Were a	utopsy findings available completion of cause of
			1 □Yes 2	ed? death? No 1 ☐ Ye	s 2□No
3	25. Was case referred to medical examiner?  1 □ Yes 2 □ No Hospital: 1 □ Inpatient 2 □ FR/Outpatient	Other:	ath (Check only one)		
2	27. Manyer of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	lome 5 ☐ Residen 28d. Describe how		ecity)
	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury	Work? M 1 ☐ Yes 2 ☐ No			
	3 ☐ Sulcide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Stre City or Town,	eet and Number or F State)	lural Route Number,
Medical Cel micanolii.	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	ath occurred at the time, date and place	e, and due to the car	use(s) and manner	as stated.
	(Check only one)  2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occu	urred at the time, dat	te and place, and du	e to the cause(s)
	29b. Signature and title of certifier	29c. License number	296	d. Date signed (Mor	th, Day, Year)
	Man ( J- Vray )	10004630	3 4	1/20	2007
	30, Name and address of person who completed cause of death (Item 23a) (Type	Padus Site	310 Ad	vapolis/M	fol
	31. Date filed (Month, Day, Year) 32. Registrar's Signature	back		, 1	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 1/2001

State Registrar Denous B. park

			1 - State of Maryland Registrar	•	rtment of H tificate of L			giene Reg. No.	20110		100
ı	Physicia		1. Decedent's Name (First, Middle, Last)				2. Date of Dea Month Septembe	Day	, 2009	3. Time of 8:40	Death /
1.00	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death			ounty of Death		·
			43035 Marwood Court		Leonar				St. Mar		
	Funeral Director		5. Social Security Number 6. Sex 1 ☒ M 2 ☐ F 7. Age (In yrs. last	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day June 24	, Year) 192	Coun	lace (State o try) ngton,	
	פ		Usual Residence of Decedent	Town or Loca	ation		ounc 21	,		0d. Inside Ci	
	Maryla f sho	tor		eonard.						1 X Yes	-
	r 28a	Director	Maryland   St. Mary's   L   10e. Street and Number	eonarc	10f. Zip Code			10g. Citizer	n of What Coun	try?	
	th witl		43035 Marwood Court		20650	)		US	SA		
	r dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	. 13. W	as Decedent of H Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White, e		
036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, it a fivelical Examinar must be notified at or other traumatic event, it a fivelical Examinar must be notified at	þ	1 ☐ Never Married 2 🕅 Married 1 ☐ Yes 2 🕅 No If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	□Yes 2 <b>X</b> No	Specify:		Sp	pecify: Wh	ite	
5-0	"natur	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occup- ind of work done of O NOT use retired	during most of work	ing	16b. Kind	of Business/Inc	iustry	
212	d withir giene. rr than	omo	Elementary/Secondary (0-12) College (1-4or 5+)			″ Mechanic		Carpe	enter		
nd	tal Hygid d other	Be (	17. Father's Name (First, Middle, Last)			18. Mother's Nam					
ryla	2 should to and Menions is marked raumatic	ျှ	George Cletus Comer  19a. Informant's Name/Relationship (Type. Print)	10h Mailine	Address (Street	Francis and Number or Ru				Code)	
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ore,	ges 1 a t of He If item or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Removal from State  20b. Pla cent	ace of Dispos metery, crema	ition (Name of atory or other plac		Date		tion - City or To	•	
Baltimore, Maryland 21215-0036	t. Pa rtmer rtant: njury	1	4 ☐ Donation 5 ☐ Other (Specify) Trin		m. Garde		26, 200			1D.	
<u>В</u>	permi Depa Impo any ir	b				Hu ashington	ntt Fund Rd. Wa	erall Idorf	ноте , Maryl	and, 2	0601
			23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ente	r the mode of dyin	ng, such as cardiac	or respiratory ar	rest,		Approximate Interval Bet Onset and I	ween
4	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	375					9	Onoct and t	Joann
	Examiner		Due to (or as a or seque	ence of):							
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	± 50 €		TE FEMALE.								
Вох	eath certific attending p for use as t	jan/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnand 1 ☐ Live birth 2 ☐ Fetal d	death 3 🗌	Ectopic pregnanc	у		230	d. Date of delive		Ye ar
P.O.	uires that the de signed by the a d be detached f	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of dea	ath 5∐	Other (specify) _						
S, D	ss that gned b	by Pł	Part II. Other significant conditions contributing to death but not result	ting in the und	derlying cause give	en in Part I.	23e. Did to		contribute to the	ne cause of d	leath?
ord	w require s been si should b	ted	<u> </u>				1 🗆 \	~		ably 4 🗌 l	
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ţ	lan: T	Be C	25. Was case referred to medical examiner?			26. Place of Dea		2 No	1 ☐ Yes	2 🗆 NO	
<u>&gt;</u>	hysic this ce	P.	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ El			4 LI Nursing H	ome 5 Resid			y)	
UC C	ding F	ion:	27. Manner of Death Natural 5 Pending 2 Accident Accident Accident State of Injury 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Work	yat <br Yes 2 □ No	28d. Describe f	now injury o	occurred		
VISIO	Atten	Certification:	2	ne, farm, stre		163 2 110	28f. Location (S	Street and I	Number or Rure	d Route Num	nber,
Ö	ital or irs afte ral Dir lled in	Cert					City or Tov				
	To the Hospital or Attending Physician: The I within 24 Hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical	29a. Certifier (Check only one) (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	rledge, death on and/or inv	occurred at the tirestigation, in my o	me, date and place prinion, death occu	, and due to the rred at the time,	cause(s) a date and pl	nd manner as s lace, and due to	stated. o the cause(s	s)
	To th within To th comp	Me	29b. Signature and title of certifier		29c. Licens			29d. Date s	signed (Month,	Day, Year)	-
			· mn		MC	10557	2 \	9	123	109	
	NAG		30. Name and address of person who completed cause of death (Item 2			OF Loops	ndtown	Mary	land 2	20650	
	Sta	te	Jennifer Schmidt, 40900 Merchant 31. Date filed (Month, Day, Year)  32. Registrar's Signatu	ire		oo, Leona	ir u cowii,	mary	ranu, Z	.0000	
	Registr		SEP 2 4 2009 Januar A	9. Apa	ake						

### Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Seplember Disharoon James Gregory 18,2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Doctors Community Hospital Lanham 8. Date of Birth (Month, Day, May 15, Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 1 ☐ M 2 ☐ F Months Days Hours Min 82 Yrs Washington, D.C. 1927 577-34-5857 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Director Lanham MD Prince George's 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20706 USA 7305 Powhatan Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1968 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🔼 No Specify 2 White 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) sharoon, Elementary/Secondary (0-12) College (1-4or 5+) Clerical U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be file tment of Health and Mental H tant: If Item 27 is marked oft jury or other traumatic even Leffert S. Disharoon Agnes E. James 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Paul G. Disharoon/Son 50406 Point Look-Inn Lane, Scotland, MD 20687 Department of Health Important: If Item 27 any injury or other tronge. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 9/22/2009 | Baltimore, Maryland Bayview Crematory 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Beall Funeral Home 6512 NW Crain Hwy., Bowie, MD 20715 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sepsis **Physician** /Medical Due to (or as a consequence of): Examiner Respirator Sequentially list conditions, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner that the death certificate be executed burial-transit Renal Due to (or as a consequence of) Box 68760. En caphalopet Physician/Medical the attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 5 Other (specify) ☐Yes 2☐No P.O. 9 Unknown 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>م</u> 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? icate has t page 2 s autopsy performed 1 ☐Yes 2 ☐ No certificate 3 1 ☐Yes Division of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2☑No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. n 24 hours after death. le Funeral Director: A pletely filled in by the fi 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

State

Registrar

within 2

Medical

29a. Certifier (Check only one)

29b. Signature and title of certifier

31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DHMH 17 Rev 1/2001 **ORIGINAL** 

29d. Date signed (Month, Day, Year)

3. Time of Death

1 ☐Yes 2 XNo

Approximate Interval Between Onset and Death

Year

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 17,2009 **Physician** Mark Joseph DeMartini 11:17 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Southern Maryland Hospital Prince George's <u>Clinton</u> Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Country) 14,1931 New York Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 77 November Yrs. **Director** 508-38-5056 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits show if than "natural", or items 23a or 28a-f sho 1 Tyes 2 Tho Director Maryland Charles Brandywine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15527 Woodville Road by Funeral 20613 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Specify: White 1 □Yes 2 No 3 🗆 Widowed 4 🗆 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 3 College (1-4or 5+) Elementary/Secondary (0-12) Sonar Tech Senior Chief U.S. Navy other 7 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mark DeMartini Mary Sarra 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Patricia DeMartini/Wife 15527 Woodville Rd., Brandywine, MD 20613 or other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Arlington National Cem. 20a. Method of Disposition November 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 17,2009 Arlington, VA 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service License -M00817 PO Box 128, Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ACUTE ATHEROSCLE PUTIC CARDIOVASCULAR IS SEATE /Medical Due to (or as a consequence of) Examiner DONARY ARTER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine physician and s the burial-trans Due to (or as a consequence of): Physician/Medical for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🔲 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Diabetes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown maliatus Completed 24b. Were autopsy findings available prior to completion of cause of death? Hypertenena 24a. Was an autopsy performed 2 No Chronc 1 ☐ Yes No Opsmonre DISCAJE. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 P/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred **Natural** 5 Pending

Division of Vital Records, P.O. Box 68760,

filed within 72 hours after death

Pages 1 and 2 should be 1 nent of Health and Mental

Baltimore, Maryland 21215-0036

Physician: The law requires that the death certificate be executed this certificate has been s al director, page 2 should has To the Hospital or Attending Plewithin 24 hours after death.

To the Funeral Director: After the completely filled in by the funeral After

investigation

6 Could not be determined

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier



29d. Date signed (Month, Day, Year) K Wy rustes. WD D50689 09/18/2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ANILK. MAHATAN MD SOUTHERN HUSDITAZ CENTER SURDATTE ROAD 7.503 CLINMIN Registrar

Decrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

			_ For	epartment of Health and I Certificate of Death	Reg. No	0000 000000
	Physicia		1. Decedent's Name (First, Middle, Last)  Roberta Ann Dooley		2. Date of Death Month Da September	y Year 22, 2009 3:57 p M
1	/Medic Examin		4a. Facility Name (If not institution, give street and number) 23239 Lake Drive	4b. City, Town, or Location of Death Lexington Park	4c.	County of Death St. Mary's
	Funeral Director		5. Social Security Number 218-80-4749  6. Sex 1 □ M 2 □ XF  7. Age (In yrs. last birth	Months   Days   Hours   Min.	8. Date of Birth (Month, Day, Year) 03/16/1936	9. Birthplace (State or Foreign Country) Maryland
	Maryland f show	tor	Usual Residence of Decedent  10a, State 10b. County 10c. City, Town of the County 10c. City, Tow		<del>-</del>	10d. Inside City Limits 1 □Yes 2 ☒No
	or 28a-	Director	Maryland St. Mary's Leonard  10e. Street and Number	10f. Zip Code	10g. Ci	tizen of What Country?
	ath wil		40595 Palmer Lacey Lane	20650		ted States
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evanting must be notified at once.	by Funeral	11. Marital Status  1 □ Never Married 2 M Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 M No If Yes, Give Year or Dates:	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert</li> <li>□ Yes 2 No Specify:</li> </ol>	pecify Yes or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
21215-0036	ithin 72 hou ne. han "natura e Medical E	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of wor life. DO NOT use retired)	king	find of Business/Industry
12	Hygiel Hygiel ther tl	S	12 Sto	re Owner	Full ne (First, Middle, Maider	rniture
and	d be f ental   ked o	To Be	Robert Miedzinski	Lillian	•	,
Maryland	shoul and M s mar umat	۲		Mailing Address (Street and Number or Ru		or Town, State, Zip Code)
	and 2 ealth n 27 i			239 Lake Drive, Lex		
altimore,	ges 1 it of H if iter or oth		1 Liburial 2 #4 Cremation 3 Li Removal from State 1	Disposition (Name of crematory or other place)		ocation - City or Town, State
I i	iit. Pa artmer ortant: injury		4 □ Donation 5 □ Other (Specify) Brinsf:  21. Signature ⊙ Funeral States the	ield-Echols Cre 09/2 22. Name and Address of Facility Br		
Ba	Depti Impo any l		Edward N. Brinsfield, Jr. M00052  23a. Part 1. Enter the disease, or complications that caused the death. Do not	22955 Hollywood Rd	., Leonardt	
	Physician /Medical Examiner	ıer	shock, or heart failure. List only one cause on a line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of Due	Concel		Interval Between Onset and Death
68760,	fficate be executed g physician and ss the burial-transit	edical Examiner	Cause (Disease or injury that initiated events resulting in death) Last  C	):		
O. Box	the death certifi y the attending ched for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delivery Month Day Year
rds, P.	law requires that the de as been signed by the a 2 should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the	the underlying cause given in Part I.		use contribute to the cause of death?
of Vital Records,	: The law requii cate has been s	Completed			24a. Was an autopsy performed? 1 □Yes 2 🔼 N	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
VIII.	sician certif rector	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 MNo  Hospital: 1 ☐ Inpatient 2 ☐ ER/Out	26. Place of Dea	ath (Check only one)	Daugner's
0 l	g Phy er this eral d	n: To	27. Manner of Death 28a. Date of Injury 28b. Til	me of   28c. Injury at	28d. Describe how inju	ry occurred
Division	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate hy completely filled in by the funeral director, page	Certification: To	Month, Day, Year)  Inj  Accident  S □ Pending investigation  Suicide  □ Could not be determined  Month, Day, Year)  Inj  (Month, Day, Year)  Inj  28e. Place of Injury - At home, farr building, etc. (Specify)	M 1 □Yes 2 □No	28f. Location (Street a City or Town, State	and Number or Rural Route Number, te)
ľ	To the Hospital within 24 hours a To the Funeral I completely filled	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and and manner stated.			
	vithin To the	Me	29b. Signature and title of certifier	29c. License number	29d. D	ate signed (Month, Day, Year)
			· Smm	HW5578	51 0	11 23 109
			30. Name and address of person who completed cause of death (Item 23a) (T			0650
10	ll) Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	hants Lane, Leonard	town, MD 2	0650
	Pegiete		SEP 2 4 2009 Varia A.	And the		

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 7:15 A M 23, Catherine Vinette Dovell 2009 September 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Calvert Solomons Nursing Center Solomons If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Date of Birth (Month, Day, Year) Days 1 □ M 2 🖾 F April 14,1912 District of Columbia 579-24-8351 97 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Leonardtown Maryland St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 42134 Medley's Neck Road 20650 IISA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 🔀 No Specify 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 10 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robert Beall Caroline Loveless 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 523 Cozy Corner Circle Duncansville, PA 16635 Rita Pummill / Sister 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virginia 25, 2009 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 21. Signature of Funeral Service Licen uchael Approximate Interval Between Offset and Death 23a, Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) esliv Dng ear Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ NO 5 Other (specify) 4 Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy 2 No 1 Yes 1 □Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 1 ☐ Yes 2 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

**Physician** /Medical Examiner

permit. Pages 1 and 2 s Department of Health a Important: If item 27 is any Injury or other trau once.

**Physician** 

/Medical

Examiner

Director

2

Completed

2

**Funeral** 

Director

ith and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Expredient mast be rectified at

filed within 72 hours after death with

Pages 1 and 2 should be

Baltimore, Maryland 21215-0036

Examine burial-transit physician Physician/Medical the attending pl certificate has been signed by the rector, page 2 should be detached þ Certification: To Be Completed funeral director, After this neral Director: Af within 24 hours a

To the Funeral C

completely filled

or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

1 🔲 Inpatient 28b. Time of

2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifier

5 ☐ Pending

investigation 6 Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year) 200

MD 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

130 HOSP. RD Prince Fre Shule 300 ANWAR MUNSHIMD

31. Date filed (Month, Day, Year) State SEP 2 4 2009

27. Manne of Death 1 Natural

2 Accident

4 Homicide

3 Suicide

Registrar's Signal

Registrar

Medical

			State Registrar		Cer	tificate of l	Death	Reg	g. No. 🤈 🗎 🗎 🔾	32295
Н	Physicia		1. Decedent's Name (First, Middle, Last) William Irving D	iffenderfer				2. Date of Death Septembe	er <sup>Day</sup> 21, 2009	3. Time of Death 8:20 P M
	/Medic Examin		4a. Facility Name (If not institution, give s			4b. City, Town, or	Location of Death		4c. County of Death Frederick	
	Funeral Director		5. Social Security Number 6. Sex 579–48–0603	7. Age (In yrs	s. last birthday) 76 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Oct 23,	9. Birthpl Year) 1932 Washi	ace (State or Foreign ry) ngton DC
	Maryland a-f show fied at	tor	Usual Residence of Decedent  10a. State 10b. County  MD Frederick		city, Town or Loc	cation			10	d. Inside City Limits 1 □Yes 2 ▼No
	th with the 23a or 28a ust be not	ral Director	10e. Street and Number 6907 Hackberry Cou	ırt		10f. Zip Code 21 703			g. Citizen of What Count SA	ry?
36	72 hours after death with the Maryland natural", or items 23a or 28a-f show Jiest Examinar mast be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates: 1953		Vas Decedent of H f Yes, specify Cuba I □ Yes 2 X No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - America Black, White, e	tc.
215-00	s within 72 hours after death with the Marylan jann. I than "natural", or items 23a or 28a-f show the Modical Examinar mast be notified at	Completed	15. Decedent's Educ (Specify only highest grade	eation	16a. Deced (Give life. L	dent's Usual Occup kind of work done o	durina most of work	ing	6b. Kind of Business/Ind	ustry
Baltimore, Maryland 21215-0036	be filed Ital Hyg Id othe event,	Be	12 17. Father's Name (First, Middle, Last) William Irving Dif	fenderfer	Letter	Carrier	18. Mother's Name	e (First, Middle, Ma	U.S. Postal	service
, Mary	s 1 and 2 should be if Health and Ments item 27 is marked other traumatic ev	To	19a. Informant's Name/Relationship (Tyr.) Blanche L. Diffend	oe. Print)		-	and Number or Rui	al Route Number,	City or Town, State, Zip	Code)
imore	8 O L		20a. Method of Disposition 1 ☐ Burial 2 ☒ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	a manual frame Canas		natory or other plac	e) ¦		oc. Location - City or To	wn, State
Ball	permit. Page Department Important: If any injury or		21. Signature of Funeral Service License Language Languag	ette MOI	251 Be	everly L.	Heckrott	e, P.A.	e P.O. Box Clarksville	
	Physician   Medical	edical Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a conse	equence of):	path	<del>y</del>			Interval Between Onset and Death
O. Box	law requires that the death certifica as been signed by the attending pt 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o	tal death 3 🛚	Ectopic pregnanc Other (specify)	у		23d. Date of delive Month	ry Day Year
rds, P.	w requires that s been signed t should be deta	by	Part II. Other significant conditions con	tributing to death but not re	esulting in the ur	nderlying cause giv	en in Part I.	23e. Did toba	acco use contribute to the	
	The ate h page	Completed	Coronary End stace	Avtenja e Per	ral_	Diseo	ise	24a. Was an autopsy perform 1 □ Yes 2	prior to condeath?	osy findings available inpletion of cause of 2 No
n of Vit	To the Hospital or Attending Physician: whith 24 hours after deals after deals. To the Funeral Director: After this certific completely filled in by the funeral director;	ion: To Be	27. Mann of Death 1 Natural 5 Pending	ospital: 1 ☐ Inpatient 2   28a. Date of Injury (Month, Day, Year)	28b. Time of	28c. Injur Worl	er: 4  Nursing He	th (Check only one pome 5 Presider 28d. Describe how	nce 6 ☐ Other (Specif	()
Division	tal or Attencrs after death al Director: ed in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spe	home, farm, str cify)		Yes 2□No	28f. Location (Str. City or Town,	reet and Number or Rura , State)	l Route Number,
	the Hospii nin 24 hour the Funer: npletely fill	Medical	(Check only 2 Medical Examinate)	sician: To the best of my k ner: On the basis of exami and manner stated.		vestigation, in my o	pinion, death occu	rred at the time, da	ate and place, and due to	the cause(s)
	15th	2	29b. Signature and title of certifier	> MD		29c. Licens		I	ad. Date signed (Month,  9-23-  - reden 1:	
	D Sta	te	Hemen Shah  31. Date filed (Month, Day, Year)	mpleted cause of death (It	omas	John	son	Dr, <del>Ť</del>	Exederis	CK MD

State of Maryland / Department of Health and Mental Hygiene

			1 - State Registrar	ce of Maryland / Depa Cer	tificate of Death		3. No. 2 1119 11296
	Physici	an	1. Decedent's Name (First, Middle, Last)	RUCHER		2. Date of Death Month Sept. 21	Day Year 3. Time of Death 2009 1:14 P M
	/Medic		4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of D		,2009   1:14 P M
A.	LAdiiiii	iei	411 141st St.		Ocean City		Worcester
	Funeral Director		5. Social Security Number 6. Sex 1 M 20	7. Age (In yrs. last birthday) 62 Yrs.	If Under 1 Year If Under 24 Months Days Hours M	Hrs. 8. Date of Birth (Month, Day, 11/2/1946	9. Birthplace (State or Foreign Country) Wash DC
	and ow		Usual Residence of Decedent  10a. State  10b. County	10c. City, Town or Loc	cation		10d. Inside City Limits
	Mary a-f sh	tor	MD Worcester	Ocean Cit	٧		1 Yes 2 No
	or 28	Dire	10e. Street and Number		10f. Zip Code	10	g. Citizen of What Country?
	s 23a	eral	411 141st St.	D	21842	2 (Chasifu Van av Na	USA 14. Race - American Indian,
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Eventinal rulal be notified at once.	by Funeral Director	1 Never Married 2 Married 1 If Ye	Yes 2. No	Vas Decedent of Hispanic Origin' Yes, specify Cuban, Mexican, Pi ☐Yes 2☑No Specify:	r (Specify fes of No- uerto Rican, etc.)	Black, White, etc.  Specify: White
21215-0036	72 hor	Completed	15. Decedent's Education (Specify only highest grade comp	leted) 16a. Deced	lent's Usual Occupation kind of work done during most of DO NOT use retired)	working 1	6b. Kind of Business/Industry
121	within iene.  than "	ldm	Elementary/Secondary (0-12) Coll	ege (1-4or 5+)			
d 2	filed v I Hygid other ent, II	Be Co	12 17. Father's Name (First, Middle, Last)		istrative assis	Name (First, Middle, Ma	ondo rentals  aiden Sumame)
Maryland	ould be to Mental arked o atic eve	To B	Richard Chaddock		Grace	(mother's	maiden name unknown)
nar)	2 should and M Is marl		19a. Informant's Name/Relationship (Type. Prin		g Address (Street and Number o		
	1 and Health em 27 ther t		Stacey Derocher (da 20a. Method of Disposition	ughter) 12903	Church Hill Ri	dge Cir #9	Germantown, MD 20874
nor	Pages nent of ant: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal 4 ☐ Donation 5 ☐ Other (Specify)	from State 20b. Place of Dispose cemetery, crem	i	22/2000 5	rankford DE
Baltimore,	permit. F Departm Importar any Injur		21. Signature of Funeral Service Dicensee	22	open Crem. : 9/	he Burhage	Funeral Home
ä	B D D D D D D D D D D D D D D D D D D D		lesson / dus	<b>~</b> 10:	8 William St. B	erlin, MD	21811
	Physician /Medical Examiner			e on each line.	yo cardial m wrote heart		Approximate Interval Between Onset and Death HOUR
68760,	rtificate be executed ng physician and as the burial-transit	ledical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	ue to (or as a consequence of): ue to (or as a consequence of):			
O. Box	death ce e attendii id for use	Physician/Me	in the past 12 months?		Ectopic pregnancy Other (specify)		23d. Date of delivery Month Day Year
۰, ۳.	s that med b e deta	by Pt	Part II. Other significant conditions contributing	0		23e. Did toba	acco use contribute to the cause of death?
ord	equire sen siç ould b	ted t	lymphople	ismacytic by	mphoma	1 ☐ Yes	s 2 No 3 Probably 4 Hunknown
Division of Vital Records,	The lar	Completed		V		24a. Was an autopsy perform 1 □Yes 2	prior to completion of cause of death?  I Yes 2 No
ξ	Physician: r this certifica ral director, p	o Be	25. Was case referred to medical examiner?  1 ☐ res 2 ☐ No Hospital	1 ☐ Inpatient 2 ☐ ER/Outpatien	Other	Death (Check onl one	nce 6 Other (Specify)
6 ر	ding Phy h. After thi funeral o	n:T	27. Manner of Death 28a.	Date of Injury 28b. Time of (Month, Day, Year) Injury		28d. Describe hov	
Sior	Attending ir death. ector: After by the fune	catic	2 Accident investigation		M 1 □Yes 2 □No		
Divi	al or Att s after d Il Direct ed in by i	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e.	Place of injury - At home, farm, strebuilding, etc. (Specify)	eet, factory, office	28f. Location (Str. City or Town,	eet and Number or Rural Route Number, State)
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	Medical C	(Check only 2 Medical Examiner: Or	To the best of my knowledge, death n the basis of examination and/or ind d manner stated.			tuse(s) and manner as stated.  Ite and place, and due to the cause(s)
	Vithi Com	Σ	29b. Signature and title of certifier	Jemich M.D.	29c. License number	1 (MD) 25	Delto Signed (Month, Day, Year)
	)		30. Name and address of person who complete			1777	
E	T 10		RODWET A. WENRICH		S. DIVISION ST	SALISB	URY MD 21804
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature			-

1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician AM MILDRED KATHERINE SEPTEMBER 18 20091 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Ellicott City Heartlands Senior Living Village Howard If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, July 2, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 ☐ M 2 🗓 F July Virginia Yrs 1922 87 Director 579-18-9826 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Tyes 2 No by Funeral Director MD Ellicott City Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21043 3004 N. Ridge Road H210 "natural", or items 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify. Specify: White 3 X Widowed 4 ☐ Divorced Be Completed 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. tem 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) LPN Healthcare 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Mildred Godsey Lacy Aubrey Baldwin ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any Injury or other tra once. Jenifer G. Eden/daughter 4945 Webbed Foot Way Ellicott City, MD 21043 20a. Method of Disposition
1 ☐ Burial 2 🖔 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Final Journey Crematory 09/21/09 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Göilig Holles Cremation Service P.O. Box 784 htto MO1251 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Object and Death ONGESTIVE HEART FAILURE Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Valvala heart disease Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner KIDNEY disease Hospital or Attending Physician: The law requires that the death certificate be executed NONIC Due to (or as a consequence of): Physician/Medical Mulletus IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Year Month Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ MCES No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 2 No 1 Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Sother (Specify 153.5 Kel Like 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To hours after death.

Ineral Director: After this y filled in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) 29c\_License number 29d. Date signed (Month, Day, Year) P 29b. Signature and title of celtifier September 18, 2009 2856 I. LEVINE, M.D TERRY 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 ATUKENT PKWY SuiTE COLUMBIA, MD 21044 -ITTL 104 State legistrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

10	Examir	er	4a. Facility Name (/	f not institution	give street and number)			4b. City, Town, o					County of E	
1,75					Rehab Cent	er		Frede					Frede:	
	Funeral Director		5. Social Security N 229-38-82 Usual Residence of	64	6. Sex 7. Age 1 ☑ M 2 □ F	75	as <i>t birthd</i> ay) Yrs.	Months Days		der 24 Hrs. s Min.	8. Date of Bi (Month, Di July 1	ay, Year)	34 V	Birthplace (State or Foreigr Country) 'irginia
	land w		10a. State	10b. County		10c. City	, Town or Loc	ation	-					10d. Inside City Limits
	Mary a-f sh	ţċ	Maryland	Fred	erick	ī	Valker:	sville						1 □ Yes 2 📉 No
	h the	Director	10e. Street and Nur					10f. Zip Code				-	zen of Wha	•
	th wit		8841 Seel	kers Wa	lk			2179	3			Un:	ited	States
	r dea	Funeral	11. Marital Status		12. Was Decedent I Armed Forces?		6. 13. V	Vas Decedent of Yes, specify Cub	Hispanic ban, Mexi	Origin? (Spe can, Puerto F	cify Yes or Ne Rican, etc.)	0- 1		American Indian, Vhite, etc.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evaninar must be notified at	Completed by Fu	1 ☐ Never Marri 3 ☐ Widowed	_	ed 1 ⊠Yes 2 □ N If Yes, Give Year or Dates:		()	□Yes 2⊠No						White
5-(	"natu	lete	(Spec	15. Decedent cify only highes	s Education t grade completed)		16a. Deced	ent's Usual Occu kind of work done OO NOT use retire	pation during m	nost of workin	g	16b. Kir	nd of Busin	ess/Industry
12	within ene. than	Щ	Elementary/Seco	ndary (0-12)	College (1-4or 5	+)		r Trades				Con	nstru	ction
9	filed Hygi Sther ent, t		17. Father's Name	(First, Middle, I	.ast)				T	other's Name	(First, Middle	e, Maiden l	Surname)	
an	id be lental ked o	To Be	Emmett Fa	armer					Lu	cy Hic	kman			
ary	shou and M s mar umat	-	19a. Informant's N	ame/Relationsh	ip (Type. Print)		19b. Mailin	g Address (Stree	t and Nui	nber or Rura	Route Numl	ber, City or	r Town, Sta	nte, Zip Code)
Ξ	and 2 salth a 27 ls		Barbara l	Farmer	/ Wife		8841	Seekers	Wa1k	, Walk	ersvil	le, 1	MD 21	793
ore	of He fitem		20a. Method of Dis		3 ☐ Removal from State	20b. Pl	ace of Dispos	sition (Name of natory or other pla	ace)	Sept.	25.	20c. Lo	cation - Cit	y or Town, State
Ĕ	Pag ment ant; I		4 □ Donation			Res	thaver	Cremato	ory	200		Fred	lerick	k, Maryland
Baltimore,	permit. Pages 1 and 2 si Department of Health an Important; If item 27 Is I any injury or other traui		21. Signature of Fu	iperal Service I	icensee									ody P.A. MD 21701
			23a. Part 1. Inter	e disease, ir	omplications that caused	the death	. Do not ente	er the mode of dy	ing, such	as cardiac o	r respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cruse disease or condition	(Final	Metastat		ncer							Onset and Death Days
	/Medical		resulting in death)		Due to (or as	a consequ	ence of):							20,0
-40	Examiner		Sequentially list co	nditions.	b									
	ed sit	ine	Sequentially list co if any, leading to in Cause (Disease or that initiated events	mediate	Due to (or as	a consequ	ence of):							
_	xecut and Il-tran	Examiner	that initiated events resulting in death)	Last	c Due to (or as	a consequ	ence of):							
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687	ificate g phys	edic			d							1.		
XO	anding use a	N	IF FEMALE: 23b. Was deceden	t pregnant	23c. If yes, outcome			1=				1 2	23d. Date o	of delivery
O. B	that the death certificate be executed sed by the attending physician and detached for use as the burial-transit	Physician/Medical	in the past 12 1 ☐ Yes 2 [	months? ⊒No	1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown			] Ectopic pregnan ] Other <i>(specify)</i> _					Month	Day Year
P.0	at the by the	hys	9 □ Unknown											
-		þ	Part II. Other signi	ficant conditio	ns contributing to death be	ut not resu	Iting in the ur	iderlying cause gi	iven in Pa	ırt I.				ite to the cause of death?
ord	w requires to been significations and been significations.	ted									1	Yes 2	<u>.</u> Mario 3[	☐ Probably 4 ☐ Unknown
ec	<u>a</u> 8 0	Completed									24a. Was	s an opsy formed?	prio	re autopsy findings available r to completion of cause of
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Division of Vital Records	ding h. After funel	ij.	1.₩Natural	5 Pending investig	(Month, Da	y, Year)	Injury	Wo	ork? ∃Yes 2		8d. Describe	r now injury	y occurred	
<u>is</u>	Atten deat ctor:	fica	2 Accident 3 Suicide	6 Could r	ot be 28e. Place of Inju	ury - At ho	me, farm, stre				8f. Location	(Street and	d Number	or Rural Route Number,
<u> </u>	al or saffer	Certification:	4 🗌 Homicide	determ	building, etc	c. (Specify	')			- 1	City or To	own, State,	)	
	To the Hospital or Attending Physician: The within 24 hours after death,  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Medical C	29a. Certifier (Check only one)		g Physician: To the best Examiner: On the basis o	f examinat								
	o the	Mec	29b. Signature and	title of pertifier	and manner sta	ated.		29c. Licen	ise numb	er		29d. Dat	e signed (/	Month, Day, Year)
_	FSFö		•	11	1 MD			D 00		_			_	25, 2009
,	-+1		30. Name and add	ress of person	who completed cause of d	eath (Item	23a) (Type I	Print)				F		•
	2.		Gaffar A					Ave., H4	, Fr	ederio	k, MD	2170	1	
	Sta	ite	31. Date filed (Mon		32. Registra	ar's Signat		/						
	Registr	rar		SEP 2	5 2009 Ken	econo	D. A	barker						
DH	MH 17 Rev 1/2	001			*									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

1. Decedent's Name (First, Middle, Last)

Harold Norman Farmer

Physician

/Medical

2. Date of Death Month Day Year September 23, 2009

3. Time of Death

РМ

3:25

			For State Registrar	State of Maryland		irtment of He <i>tificate of D</i>			giene Reg. No 2009	32299
ı	Physicia	an	1. Decedent's Name (First, Middle, Last)			E4 - 1 4 -		2. Date of Dea Month	Day Year er 22,2009	3. Time of Death 15:52 M
war.	/Medic Examin		Lula I  4a. Facility Name (If not institution, give s	See and number)		Fields 4b. City, Town, or L	ocation of Death	Septemb	4c. County of Deat	
3	Funeral Director		3570 Post Office II 5. Social Security Number 6. Sex 216-14-9620			Allen If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day August	v, Year) Co	CO hplace <i>(State or Foreign</i> huntry) ryland
	and		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Maryi a-f sho	tor	MD Wicomico		Allen					1 □Yes 2⊠No
	ith the	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of What Co	ountry?
	s 23a		3570 Post Office I		3 40 1	21810		acifu Va a or No	USA 14. Race - Ame	wicen Indian
5-0036	be filed within 72 hours after death with the Maryland tial Hyglene. do other than "natural", or items 23a or 28a-f show event, i'r. M.dfcal Evan, i'nd must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in U.S Armed Forceş? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Vas Decedent of His fYes, specify Cuban □Yes 2ঐNo	Specify:	Rican, etc.)	Black, White	e, etc.
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nd	e filed wit tal Hygien d other than	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle,	Maiden Surname)	
Maryland	should be fand Mental   s marked o' umatic eve	ပ္	Major Lee		thell	an Address (Charatan	Nellie	ral Chauta Mumbe	N: er, City or Town, State, 2	ichols
	nd 2 shallth an alth an 27 Is r		19a. Informant's Name/Relationship (Ty) Sherrie Messick- o	·	I	•			, MD 21804	zip Code)
altimore,	of Hea		20a. Method of Disposition	20b. P		sition (Name of natory or other place)		Date	20c. Location - City or	Town, State
<u>E</u>	Page tment tant; If		1 △ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State ST	ringh	ill Mem. (	Ga. 9/25,	/2009	Hebron, Ma	ryland
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E		e 116	23a. Part1. Enter the disease, or compli shock, or heart failure. List only or Immediate Cause (Final	fations that caused the death e cause on each line.	n. Do not ent	er the mode of dying	, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
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Recor	ie law require has been si je 2 should b	Completed						24a. Was autop perfo		utopsy findings available completion of cause of
<u>ra</u>	Physician: The la r this certificate ha ral director, page 2		25. Was case referred to medical				26. Place of Deat	1 □ Yes	2 <b>☐</b> √0 1 ☐ Yes	s 2□No
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Division of Vital Records,	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific; completely filled in by the funeral director,	Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	-	es 2 □No	28f. Location (S City or Tox	Street and Number or R vn, State)	ural Route Number,
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	To th To th comp	Me	29b. Signature and title of certifier			29c. License	number		29d. Date signed (Mon	th, Day, Year)
	. Oi					DOO	5443	51	4.24	-09
	Ja?		Name and address of person who co	empleted cause of death (Item	23a) (Type,	Print)	42U n	1+1/or	non led	D'Annind
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	. 4 50	15-110	VI VEL		1 MILLING
	Registr	ar	0 A ac	No.	10 1	( V.)				

			For State Registrar	State of Marylan			nt of H <i>te of L</i>		nd M		giene Reg. No.() (	110	22200
			Decedent's Name (First, Middle, Last	st)						2. Date of Dea	ath	1 10 2	3. Time of Death
	Physicia /Medio		GLORIA D. FI	SHER						SEPTEMI	3ER 17	, 2009	12:06Р м
-	Examin		4a. Facility Name (If not institution, give			4b. City		Location of	Death			nty of Death	DOEG
n gen			BOWIE HEALTH CARE			(71)	BOWI		4 1 1 mg			CE GEO	
	Funeral		5. Social Security Number 6. S	ex 7. Age (In yrs. 70	last birthday) Yrs.	Months	or 1 Year Days	If Under 24 Hours	Min.	8. Date of Birl (Month, Da OCTOBE)	h v, Year) 220 101	9. Birthi Cou	place (State or Foreign TH CAROLINA
	Director		579 50 9402 Usual Residence of Decedent	70						OCTOBE		3φ 300	III OAROLINA
	ow ow		10a. State 10b. County	10c. Cit	y, Town or Lo	cation						1	I 0d. Inside City Limits
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21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Evariance must be neithed at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Was Deco If Yes, sp 1 ☐ Yes	ecify Cuba	spanic Origi n, Mexican, Specify:	in? (Spe Puerto F	cify Yes or No Rican, etc.)	E	Race - Ameri Black, White, $_{ ext{cify:}}$ $^{ ext{BL}}$	
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ryla	nould d Mer narke	ဥ	UNKNOWN	UNKNOWN	405 14-10-		on (Chromat			l Route Numb			n Codo)
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Box	death a atter	Physician/Me	in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of a		☐ Ectopic ☐ Other (	pregnancy specify)	<i>y</i>				Month	Day Year
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S,	The law requires that the death certif ate has been signed by the attending age 2 should be detached for use as	by P	Part II. Other significant conditions of	contributing to death but not res	ulting in the u	nderlying	cause give	en in Part I.					the cause of death?
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<u>د</u>	hysician: The law his certificate has t I director, page 2 s	) m								perfo	rmed? 2 ☐No	death?	2 🗆 No
/ita	clan: ertific ctor,	Be (	25. Was case referred to medical examiner?						of Death	(Check only o			
of \	Physician: r this certifica ral director, p	ို	1 ☐ Yes 2 ☐ XNo		ER/Outpatie			41 Nurs		ne 5□ Resi			ify)
	ding Phy h. After thi funeral o	ion:	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	f M	28c. Injury Work	yat ⟨? Yes 2 □ N		28d. Describe	how injury oc	curred	
isic	Attending or death. ector: After by the funer	icat	2 Accident investigation 3 Suicide 6 Could not b		ome farm str			Yes ∠⊔N	_	Paf Location /	Street and No	imber or Bui	al Route Number,
Division	I or Atten after deat Director: I in by the	Certification:	4 Homicide determined	building, etc. (Speci	fy)	oct, idote	ry, onloc			City or To			arriodic ryamber,
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical C		nysícian: To the best of my kno niner: On the basis of examina and manner stated.									
	To the within 2 To the comple	Me	29b. Signature and title of certifier		h.	2	9c. Licens	e number			29d. Date sig	gned (Month	, Day, Year)
	FSFO			suy	7		D4	5217			09-23	-2009	
			30. Name and address of person who	completed cause of beath (Iter	m 23a) (Type,	Print)							- M10
14	-6		ADEBOWALE AJAYI	0	6261	GREE	NBELT	r RD.	GREE	ENBELT,	MD 207	40 SU]	TE M18
	Sta	te ar	31. Date filed (Month, Day, Year)  CFD 2 5 2009	.32. Registrar's Sign	all								

			For State Registrar	State o	of Maryla	nd / Depa <i>Cer</i>			leaith and Death	i Mentai	Hygien Reg. N	- m	na	3230	American co
	Dhuniai		Decedent's Name (First, Middle)							2. Date of	D	ay	Year	3. Time of Dea	
	Physicia /Medic		DAVID		RGUSON					SEPT	EMBER	22 2	2009	1:35 P	М
J.	Examin	er	4a. Facility Name (If not institution,		ımber)		-		Location of De	ath		c. County RTNCE		RGE'S	
~	Funeral		5215 LANSING 5. Social Security Number	6. Sex	7. Age (In yrs	s. last birthday)	If Unde	er 1 Year	If Under 24 H	rs. 8. Date o	of Birth h, Day, Year		9. Birtho	lace (State or Fo	reign
	Director		554-82-2442	1 € M 2 □ F	59	Yrs.	Months	Days	Hours Mi	MAY	3 195	ó	WEST	VIRGINI	A
- Pur	M I		Usual Residence of Decedent  10a. State 10b. County		10c. C	ity, Town or Lo	cation				-		1	0d. Inside City Li	mits
Many	-f she	tor	VA FAIRF	AX	F	AIRFAX								1X Yes 2□	]No
<del>4</del>	or 28a	Director	10e. Street and Number					ip Code				itizen of W	Vhat Coun	itry?	
#	23a c	rai	3262 LAURISTON					2031							
20	items	Funeral	11. Marital Status 1 X Never Married 2 ☐ Marrie	Armed F	edent Ever in lorces?	J.S. 13.	Was Dece f Yes, sp	edent of H ecify Cuba	lispanic Origin? an, Mexican, Pu	(Specify Yes o erto Rican, etc	or No- .)		k, White,		
5-0036	al', or	ρ	3 Widowed 4 Divorced	If Yes, G Year or D	<sup>2 □ No</sup> AIR oates:	FURCE .	1 □Yes	2 ₹ No	Specify:			Specify	BL	ACK	
2-0	natur	eted	15. Decedent' (Specify only highes	s Education grade completed;	)	16a. Dece	kind of w	ork done	durina most of w	orking	16b.	Kind of Bu	isiness/Ine	dustry	- (
2121	Highene. Why than "natural", or items 23a or 28a-f show shift the Medical Exertainer rust by redified at	Completed	Elementary/Secondary (0-12)	College (	(1-4or 5+)	1	PERVI	use retired [SOR	i)		PR	IVAT	Ε		
מ פ	other vent, it	Be Co	17. Father's Name (First, Middle, L	ast)	-				18. Mother's N			n Surnam	e)		
arylan	5 <del>2</del> 70 €	To B	STEWART A. FER	.GUSON					MAR	THA MAI	CTIN				
٥	2 18 18 18 18 18 18 18 18 18 18 18 18 18		19a. Informant's Name/Relationsh						and Number or DRIVE T					Code) 20748	
	Healtlem 27		RAYNINA SWANN/	AUNT	20b.					Date		Location -			
mor	nent of nert of int: If it iry or o		1 ☐ Burial 2 【ACremation 4 ☐ Donation 5 ☐ Other (Sp		i State	Place of Dispo cemetery, cren VERDALI			i .	5/2009				ARYLAND	
Baltimore,	Definit. Page Department Important: It any Injury o		21. Ship thus of Fulleral Service			22	. Name a	and Addre	ss of Facility	J. B.	JENKIN	IS FU	NERAI	HOME	
n s		0) 1)	DE P	7		74	474 ]	LANDC	VER ROA	D LAND	OVER,	ARYL.	AND 2	20785	
			23a. Part 1. Enter the disease, or on shock, or heart failure. List of	only one cause on	each line.				_	iac or respirat	ory arrest,			Approximate Interval Between Onset and Deat	n ih
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		T NEOPI	ASM	LIVE	K						
1	xaminer			Due to	(or as a conse	iquence or).									
70	± ±	iner	Sequentially list conditions, if n, cause. Enter Underlying	Due to	(or as a conse	uence of:									
yecut	and Il-tran	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	(or as a conse	quence of):									
58760, ficate be executed	physician and the burial-transit	edical E	ļ	d.											
20	ng phy		IF FEMALE:	1									J		
. Box (	attending p	ian/I	23b. Was decedent pregnant in the past 12 months?	1 Live	utcome of preg birth 2 ☐ Fe	tal death 3		pregnanc	у			23d. Dat Mo	te of deliventh	ery Day Year	,
<b>်</b> ရို	y the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 □ Unk	gnant at time of nown	rdeath 5L	Other (	specity) _			_				
ords, P.O	been signed by the should be detached	by Pr	Part II. Other significant condition	ns contributing to o	death but not re	sulting in the ur	nderlying	cause giv	en in Part I.	23e.	Did tobacco	use conti	ribute to t	he cause of death	1?
ecords,	sen sig									-	1 □ Yes	2√ No	3 ☐ Prol	oably 4 🗌 Unkr	iown
8	2 2 2	Completed								-	Was an autopsy	F	Were auto prior to co death?	ppsy findings avai mpletion of cause	lable e of
	ate	- 1	OC Man area referred to madical	-						1 🗆 1	performed? /es 2 🔼 N		1 ☐ Yes	2 ŒNo	
Vital	s certi	o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	] Inpatient 2 [	☐ ER/Outpatier		OCA Oth	or:	eath <i>(Check o</i> Home 5 🗆		6 XI Oth	er (Speci	60 AUNTS	
ָם ה קַּקְּ	th.: After this certifical funeral director, p	$\vdash$	27. Manner of Death 1 Natural 5 Pending	28a. Date		28b. Time of Injury		28c. Injui Wor			ribe how inj			MAUSE	
VISION OF VITA	leath. tor: A the fu	catic	2 Accident investign 3 Suicide 6 Could n	ation			М	1 🗆	Yes 2 □ No						
DIVISION Lor Attending	after c Direc i in by	Certification:	4 Homicide determi	ned 28e. Place build	e of Injury - At ding, etc. (Spec	home, farm, str cify)	eet, facto	ry, office			or Town, Sta		er or Hura	al Route Number,	
Canita	within 24 hours after death.  To the Funeral Director: A completely filled in by the funeral Director.			Physician: To th											
the H	nin 24 the Fu nplete	Medical	one)	examiner; On the and man	nner stated.	nation and/or in	-			ccurred at the					
٩	vitt cor	2	29b. Signature and title of certifier	J. n-			2		e number	-	29d. [	ate signe	a (Month,	Day, Year)	
	11		30. Name and address of person v	who completed cau		em 23a) (Type	Print)	140	0665		0	1/0	2/3	ruj	
16	-4		DR. Donia Les	WEKL D	0 92	00 BAS	iv C	4 5	Xe 200	Lau	go.	YND	209	174	
	Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Sig	ture								,	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Nancy Anderson Gordon  $A^M$ 2009 3:37 Sept. 20 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Gilchrist Hospice Care Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Months Days

Virginia

29d. Date signed (Month, Day, Year)

10d. Inside City Limits

Feb. 17, 1956

/Medical Examiner

**Physician** 

1 - For State Registrar

10a State

037-40-0822

Usual Residence of Decedent

10b. County

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, I'm Medical Exp. in a must be muffled at once. Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician; The law requires that the death certificate be executed burial-tran led by the attending physician detached for use as the buria signed by t cate has been signated by page 2 should b 24 hours after deatle Funeral Director; filled in by the within 2

Division of Vital Records, P.O. Box 68760,

Maryland Anne Arunde	el	Annap	olis		1 □Yes AN
10e. Street and Number 603 Burton Cove Lane		10f. Zip Code 2140	)1	10g. Citizen of What Co	
Arme  1 Never Married 2 Married  1 Yes	Decedent Ever in U.S. d Forces? les 2000 No , Give or Dates:	If Yes, specify Cuban, N	nic Origin? (Specify Yes or I flexican, Puerto Rican, etc.) pecify:	No- 14. Race - Ame Black, White Specify:	
15. Decedent's Education (Specify only highest grade complete	ted) (	Decedent's Usual Occupatio (Give kind of work done durin life. DO NOT use retired)	n ng most of working	16b. Kind of Business	/Industry
Elementary/Secondary (0-12) College	ge (1-4or 5+) 4	Nurse		Nursin	g
17. Father's Name (First, Middle, Last) James L. Anderson	•	18	Mother's Name (First, Midd Anne Berger	lle, Maiden Surname)	
19a. Informant's Name/Relationship (Type. Print)  James L. Anderson/fat	·	Mailing Address (Street and '5 Rudder Way	Number or Rural Route Nur. Annapolis,		Zip Code) 1401
20a. Method of Disposition	cemetery	Disposition (Name of , crematory or other place)	Date	20c. Location - City or	Town, State
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal for 4 ☐ Donation 5 ☐ Other (Specify)	Baltim	ore Crematory		Baltimore,	
21. Signature of Funeral Service Licensee			f Facility John M.		
23a. Part 1. Enter the disease, or complications to	/	<u> </u>	Gloucester S		Approximate
shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	e to (or as a consequence of	ian (	ancer		Inferval Between Onset and Death
Cause (Disease or injury that initiated events c Du	e to (or as a consequence of	f):			
23b. Was decedent pregnant in the past 12 months?	s, outcome of pregnancy Live birth 2 ☐ Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of do Month	elivery Day Year
Part II. Other significant conditions contributing	to death but not resulting in	the underlying cause given i		d tobacco use contribute ☐ Yes 2 No 3 ☐ F	to the cause of death? Probably 4 ☐ Unknow
			24a. W au pe 1 □ Ye	rtopsy prior to erformed? death?	autopsy findings availab o completion of cause o
25. Was case referred to medical examiner?			6. Place of Death (Check on	ly one)	
1 Yes 254No	Date of Injury 28b. T	njury Work?		esidence 6 Other (Sp be how injury occurred	ecify) Q i \CMC
a □ a · · · · · · · · · · · · · · · · ·	Place of Injury - At home, far building, etc. <i>(Specify)</i>	m, street, factory, office	28f. Location City or	n (Street and Number or I Town, State)	Rural Route Number,
29a. Certifier 1 X ertifying Physician: 7 (Check only Medical Examiner: On one)	o the best of my knowledge the basis of examination and	, death occurred at the time, d/or investigation, in my opin	date and place, and due to ion, death occurred at the tire	the cause(s) and manner ne, date and place, and d	as stated. ue to the cause(s)

53

10c. City, Town or Location

Registrar DHMH 17 Rev 1/2001

State

IDLO.

29c. License number

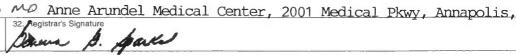
Amend #1 4A per Phy 9/22/09 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AA Co. Health Dept lo State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Elvera Colato Month 09 Day 40 **Physician** /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Anne Arundel Annapolis 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗷 F Months Days Hours Min. 177-14-2231 July 22, 1921 New Jersey Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County show ms 23a or 28a-f show 1 X Yes 2 □ No Director MD Prince George's Bowie 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20715 USA 12712 Knowledge Lane Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married 2X No Maryland 21215-0036 Specify: White ò 1 Yes 2 No th and Mental Hygiene.

7 is marked other than "natural", of traumatic event, if a Medical Example. ۵ Specify 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Massimino Amalia Valentino DeLarso 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a t: If item 2. Al James Golato / spouse 12712 Knowledge Lane Bowie, MD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If it any Injury or conce. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veteran Cem 9/23/2009 Crownsville, MD Signature of Funeral Service LIC Beall Funeral Home 22. Name and Address of Facility 6512 NW Crain Hwy. Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner RECTUM. GLUTEAL ABLESS PERFORATED Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner the Hospital or Attending Physician: The law requires that the death certificate be executed STAGE COPP and buriai-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 No ned by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe certificate 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐ No ours after death.

eral Director: After this certific filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier nuce 069482 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRASAD

31. Date filed (Month, Day, Year) SEP 22 State Registrar



			For State of Marylar  1 - State Registrar	- ·	artment of H rtificate of L			ene	10 00001
			Decedent's Name (First, Middle, Last)				2. Date of Death	Street Bart By	3. Time of Death
	nysicia Medic		Gertrude Gwendolyn Gass				Septembe	r 24, 20	009 6:05 Рм
E	kamin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of E	
,			St. Mary's Nursing Center			ardtown			Mary's
	neral ector		5. Social Security Number 6. Sex 190−18−0100 6. Sex 1	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 29,	<sup>9.</sup> 1920 Pe	Birthplace (State or Foreign Country) ennsylvania
ъ		Ì	Usual Residence of Decedent						
rylan	9	_		ty, Town or Lo					10d. Inside City Limits
Ma W	Med Mark	cto	Maryland St. Mary's			Abell			1 ☐ Yes 2X No
th the	g Lig	)ire	10e. Street and Number		10f. Zip Code		10	g. Citizen of Wha	t Country?
th wil	설	je	38674 Morris Point Road			20606		US	SA
dea		ne	11. Marital Status 12. Was Decedent Ever in U Armed Forces?	.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Sp	ecify Yes or No- Bican, etc.)		American Indian, Vhite, etc.
after after	THE STREET	by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☒ No If Yes, Give		1 ∐Yes 21X No	Specify:		Specify:	White
5-0036 72 hours after death with the Maryland fratural? or items 23a or 28a-f show	E	d b	3 ☑ Widowed 4 ☐ Divorced Year or Dates:						
<b>5-</b> 0	Hard Hard	ete	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done d	lurina most of work		6b. Kind of Busin	ess/Industry
d 21215-0036 filed within 72 hours aft Hygiene.	e Me	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. I	DO NOT use retired, Homemake	,		Own	Home
led w	, E	ပ္ပ	6		Homemake	18. Mother's Name	(First Middle Mr		
Maryland of 2 should be file th and Mental Hy	ever	Be	17. Father's Name (First, Middle, Last)						raan
V Sould	natic	ပ	Joseph Harold Getz				lan Blueb		
Mar 2 sh h and	rann	2.1	19a. Informant's Name/Relationship (Type. Print)		ng Address (Street a				
e, h 1 and Health	her		Lillian G. Goldsborough / daughte			n's Road	Date 20	Oc. Location - City	ZOOJO
imore Pages 1 Tent of F	orot		1 kd Burial 2 ☐ Cremation 3 ☐ Removal from State	cemetery, crer	sition (Name of matory or other place	e) Sente	mbor 29	•	•
timen trnen	Juny		4 Donation 5 Dother (Specify) Cha		morial Garde	ens: 200	9 T		, Maryland
Baltimore, Maryland 21215-0036  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene 19 to make 1 other than "not than 3 to an 28a-3 show	any in		21. Signature of Funeral Service License	22	Name and Address Matting1 P.O. Box	ey-Gardir 270 Lec	ner Funer nardtown	al Home. , MD 206	350 P.A.
P.O. Box 6 hat the death certification the attending	be detached for use as the burial-transit	d by Physician/Medical Examiner	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  Part II. Other significant conditions contributing to death but not res	ancy al death death 5	Ectopic pregnancy Other (specify)				
v req	shou	ete	analoge home	لازا	-		24a. Was an	24h Wor	re autopsy findings available
	funeral director, page 2 s	Completed	_ Joval we   · MINV V	0-7			autopsy perform	ed? prio	r to completion of cause of
Vital Fisician: The certificate	ector	Be	25. Was case referred to medical examiner?				h (Check only one	)	
Of \	al dire		1 ☐ Yes 2 ② No Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier		4 Windresing Ho	ome 5 Resider		(Specify)
Jn C	uner	0	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	Work	? _	28d. Describe hov	v injury occurred	
Vision Attend death ctor:	the f	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be   380 Place of Injury At b			Yes 2 □No	0001		
Division or Attendation of Attendati	in by	Certification: To	4 Homicide determined 28e. Place of Injury - At h		eet, ractory, office		28f. Location (Stre City or Town,		or Rural Route Number,
Division of Vita Vita hospital or Attending Physician: The Hospital or Attending Physician: The Funeral Director: After this certific	9 1	Medical Ce	29a. Certifier (Check only 2 Medical Examiner: On the basis of examiner.						
	Пре	Med	one) and manner stated.		29c. License	a number		d Date siz=== 4	Month, Day, Year)
			29b. Signature and the of certifier	MI	29C. License	0641	19	2-27	29
1/3	7		30. Name and address of person who completed cause of death (Itel	, , , , ,		1 . 100 . 0.00	7		1
1	/		James P Jarboe, M.D. 24035 Three		ad Hollyw	ood, MD 206	0.36		
	Sta	te	31. Date filed (Nonth, Day, Year) SEP 2 8 2009	ature &	and a				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene state Registrar Amend #26 PER PHYS 9/24/09 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day SEPT. **Physician** 21, Year 2009 4:15 P. M CLARENCE R. GILFORD, JR. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE 4016 23RD PARKWAY APT. 1 TEMPLE HILLS If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
JAN • 25 • 1949 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Months Days 1**X** M 2□ F Hours 60 Director 214-50-4272 JAN. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits f show r than "natural", or items 23a or 28a-f show the "Molical Experient must be notified at PRINCE GOERGE TEMPLE HILLS MARYLAND 1 X Yes 2 □ No 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? U.S.A. 4016 23RD PARKWAY APT. 1 20748 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc 1 □Yes 2.K If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2**X** No BLACK Specify. ģ Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 TRUCK DRIVER EDUCATION Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 should be finance and Mental permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev CLARENCE R. GILFORD, SR. MAXINE HAYNIE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4016 23RD PARKWAY APT. 1 TEMPLE HILLS, MARYLAND 20748 LEOLA GILFORD, WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State 1 Derivation 3 Removal from State WASHINGTON NATIONAL 9/26/2009 SUITLAND, MD 4□Donation 5□Other (Specify) 21. Signature of Funeral Service, 22. Name and Address of Facility 6784 MARYBALL RD BERRY O. WADDY FUNERAL HOME LANCASTER, VA 22503 23a. Part 1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause in each line. Do not enter the mode of duing, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed g physician and as the burial-trans Physician/Medica/ attending for use as IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed 1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes Certification: To 1 Inpatient 2 ER/Outpatient 3 I DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐Pending investigation Natural death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Errifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical

Division within 24 hours aft To the Funeral Di completely filled in within 2 To the I

Maryland 21215-0036

Baltimore,

Box 68760

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Records,

of Vital

State Registrar (Check only

2 4 2009

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# Baltimore, Maryland 21215-0036

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the 28a	Director	10e. Street and Number					10f. Zip Code			10g. Citizen of	What Cour	ntry?
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burning Medical Certification: To Be Completed by Division Medical	2	(Check only 2 Me	dical Exami	ner: On the ba	asis of exam	ination and/or i	nvestigation, in my	opinion, death occu	rred at the time,	, date and place	, and due to	o the cause(s)
ortho ortho compl		29b. Signature and title of q	rtifier		V )	1	29c. Licen	nse number		29d. Date sign	ed (Month,	Day, Year)
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			5430 Deale Churchton Road		Churcht			Anne Ar	undel
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	the l		10e. Street and Number		10f. Zip Code		10g	. Citizen of What Co	untry?
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21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Completed by Fu	11. Marital Status  1 □ Never Married 2 □ Married  3 ♣ Widowed 4 □ Divorced  12. Was Decedent B Armed Forces?  1 □ Yes If Yes, Give Year or Dates.	ver in U.S. 13. V	Vas Decedent of Hispa f Yes, specify Cuban, I Pes 25 No		ofy Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
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C	44		30. Name and address of person who completed cause of de 5851 - Deale  31. Date filed (Month, Day, Year) 32. Registra	eath (Item 23a) (Type, Pr	ton R	N.C.	SUR	ANA	20751
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စ်	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		20a. Method of Disposition	<u> </u>		e of Disposition (Netery, crematory of			Date		cation - City or To	own, State	
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Вох	death certif e attending id for use as	N/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			c pregnancy				23d. Date of deli Month	very Day Year	
ω.	deat e atto	icia	in the past 12 months? 1 ☐ Yes 2 ☑ No	4 ☐ Pregnant at							WOTH	Day Teal	
P.O.	t the by th ache	Physician/M	9 Unknown						00 8:1			the cause of death	2
	The law requires that the death certifi ate has been signed by the attending I page 2 should be detached for use as	by F	Part II. Other significant conditions of		ut not resulti	ng in the underlyin	g cause given i	in Part I.				obably 4 Unkn	
Ď	w require been signal	ed	MULTIPLE MYEL						1 🗆	Yes 2	MINO 3 PI	Obably 4 Olikii	IOWII
သွ	e 2 sho	plet	BREAST CANCE	R					24a. Was	psy	prior to c	topsy findings avail completion of cause	lable e of
æ	The law cate has page 2	Completed							perf 1 ⊠ Yes	ormed?	death? 1 ☐ Yes	2 No	
<u>ia</u>		Be C	25. Was case referred to medical				26	6. Place of Dea	ath (Check only	one)			
of Vital Records,	S		examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatie	ent 2 🗆 El	R/Outpatient 3	DOA Other:	4 Nursing H	Home 5□ Res	sidence	6 ☐ Other (Spec	cify)	
		١Ξ	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da		8b. Time of Injury	28c. Injury at Work?	t	28d. Describe	how inju	ry occurred		
Division	Attending r death. ector; After by the fune	atio	2 Accident investigation			М		s 2 🗆 No					
Vis	er de recto	tific	3 Suicide 6 Could not be determined	200. Flace of Hije	ury - At hom c. (Specify)	e, farm, street, fac	tory, office		28f. Location City or To	(Street all wn, State	nd Number or Ru e)	ıral Route Number,	
Ö	To the Hospital or Attendi within 24 hours after death. To the Funeral Director; A completely filled in by the f.	Certification: To											
	lospi hou uner uner		29a. Certifier 1 ✓ Certifying Ph (Check only 2 ☐ Medical Exar	nysiclan: To the best miner: On the basis o	of my know	ledge, death occur on and/or investiga	red at the time, tion, in my opin	, date and plac nion, death occ	e, and due to th urred at the time	e cause(s e, date an	s) and manner as d place, and due	s stated. to the cause(s)	
	the H in 24 the F	Medical	one)	and manner sta	ated.	7					ate signed (Monti		
_	Vait To To	2	29b. Signature and title of certifier	~		MO	29c. License n	7C-12A	8	50		2009	
			P				11047	2220	~		, 30		
(			30. Name and address of person who	completed cause of c	leath (Item 2	23a) (Type, Print)	BACTIC	nort 1	10 312	01			
أسنوا	Dob				ar's Signatu								
	St	ate	31. Date filed (Month, Day, Year)	2009	e cignatu	A. Day	Ke)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 15 2009 Melvin Howard 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Memoria astor If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sev 7. Age (In vrs. last birthday) Months Days Hours 1 M 2 □ F 213-22-942 Usual Residence of Decedent Yrs. 03-29-192 maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No evens Vi 10f. Zip Code Md 10g. Citizen of What Country? 10e. Street and Number 21666 SA 12, Was Decedent Ever in U.S.
Armed Forces?
1 | Yes 2 | Tho
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify Black 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Unknown Naterman 18. Mother's Name (First, Middle, Maiden Surname) 17, Father's Name (First, Middle, Last) Tarrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Rd. larrington De. 19952 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Staytenville astine Days / daughter Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F 3 Removal from State 09-19-2009 Stevensy. ile, md. Cemetery 107-17-200 1310 Constant Funeral Ham
22. Name and Address of Facility Benn: eSmith Funeral Ham 1. Signature of Fucural S vice Licensee 426 Dover St. Easton, Md. 21601 23a. Part 1. Enter the disease, or complications that shock, or heart failure. List only one cause on used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Sepho Shock Due to (or as a consequence of): Sequentially list conditions, if any leading to him ediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Non Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Day 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Were autopsy findings available prior to completion of cause of

Physician /Medical Examiner

Physician

/Medical

**Examiner** 

Director

Be Completed by Funeral

2

Director

d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at

21215-0036

Maryland

Pages 1 and 2 should be one of Health and Mental

permit. Pages 1 and 2 shoul Department of Health and M Important: If item 27 Is mark any Injury or other traumath

or other traumatic

The law requires that the death certificate be executed

Records,

Division of Vital Hospital or Attending Physician: Physician/Medical Examiner

\$

Completed

Be

Certification: To

Medical

ned by the attending physician detached for use as the buria certificate this 24 hours after death.

Funeral Director: After the etely filled in by the funeral

IF F	EMALE:
23b.	Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

autopsy rmed? 2 kd No

1 ☐Yes 2 ☐ No

examiner?	1
27. Manner of Death	
Natural	5 Pending
2 Accident	investigation

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 28d. Describe how injury occurred

26. Place of Death (Check only one)

1 ☐ Yes

3 Suicide 4 ☐ Homicide 29a. Certifier

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

(Check only one) 29b. Signature and title of certifier

6 ☐ Could not be

29c. Ligense number 31546

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

30. Name and address of person'who completed carrie of death (Item 23a) (Type, Print)

219 Washington S

State Registrar 31. Date filed (Mbnth, Day, Year) SEP 18 2009

32. Registrar's Signature

within 2

Division or Vital Records, P.O. Box 68760, To the Hospital or Attendi within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

341-4 State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FARID mun - SHED 31. Date filed (Month, Day, Year)

32. Registrar's Signature SEP 28 2009

and manner stated

29a. Certifier

(Check only one)

29b. Signature end title of certifier

Medical

1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

0060396

opal

29d. Date signed (Month, Day, Year)

a D

28/09

21740

			1 - State of Maryland / Dep	artment of Health and I		ene g. No. 2009	3231
	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  VALERIE F KAGIAN		2. Date of Death Month		3. Time of Death
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
<i></i> *	Funeral		717 Petersburg Rd.  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  1.46-38-7481  1 M 2 F  60 Yrs.	Davidsonvil   If Under 1 Year   If Under 24 Hrs.   Months   Days   Hours   Min.		Anne A	runde L hplace (State or Foreign ountry) NY
	Director		Usual Residence of Decedent		12/9/19	740	NI
	show	_	10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits
	the Ma 28a-f	ecto	MD Anne Arundel David	lsonville   10f. Zip Code	10	g. Citizen of What Co	1 Yes X No
	3a or	a Di	717 Petersburg RD.	21035		USA	,
0000	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the modified Evar, that it until be notified at or other traumatic event, the modified Evar, that it until be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 Married  1 □ Never Married 2 Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes 2☐No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, White Specify:	
5	72 hou	eted	(Specify only highest grade completed) (Giv.	edent's Usual Occupation e kind of work done during most of wor		6b. Kind of Business/	Industry
7	within ene.	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)		Substance	Abuse
2	filed v Hygie other ent, tr	Be Co	17. Father's Name (First, Middle, Last)	Councilor  18. Mother's Nan	ne (First, Middle, Ma		Abuse
	uld be Mental arked atic ev	To B	Robert Victor Fortune	Marian	na Mackir	1	
, Mar	permit. Pages 1 and 2 shou Department of Health and M Important: If item 27 is mar any injury or other traumat once.			ing Address (Street and Number or Ru Petersburg Rd. D			
บ บ	ges 1 at of He If item or oth		20a. Method of Disposition 1 ☐ Burial 2★Cremation 3 ☐ Removal from State 20b. Place of Disposition cemetery, cre	osition (Name of ematory or other place)		0c. Location - City or	
Dallillo	iit. Pag irtimen irtant: njury		4 □ Donation 5 □ Other (Specify) Atlantic			Len Burnie	
Ö	permi Depar Impor any ir		1 145 () ('V	Hand Address of Facility Ha		ineral Hom	e, P.A.
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  a. Due to (or as a consequence of):				Approximate Interval Between Onset and Death
L		I Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c. Due to (or as a consequence of):				
00/00	ficate I g physics the b	edical	d				
. DOX	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of de Month	livery Day Year
ŗ.	s that i	by Ph	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to	the cause of death?
cords,	equire een sig ould b	ted b			1 ☐ Yes	s 2 No 3 P	robably 4 Unknown
ם בי	The law rate has be page 2 sh	Completed			24a. Was an autopsy perform 1 □ Yes 2	prior to death?	utopsy findings available completion of cause of
V   [a	ician: certific ector,	Be	25. Was case referred to medical examiner?  Hospital: Hospital:	Othor:	ath (Check only one	)	
5	Physer this	): To	27. Manner of Death 28a. Date of Injury 28b. Time	SIT 3 DOA 4 Nursing F	lome 5 Resider 28d. Describe how	nce 6 Other (Spe winjury occurred	ecify)
5	arding ath. ir: Afte	atior	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
	after de after de I Directo d in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or R State)	ural Route Number,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deadlers of examination and/or and manner sketed.				
	To th within To th comp	Me	29b. Signature and title of certifier	29c. License number		d. Date signed (Mont	
			TWW CO J HIW IN	11 1) 2143	s Je	ptembe	v 21, 2009
0	45		30. Name and address of person who contileted cause of death (Item 23a) (Type MICHITEL LA FENTA WY +45	Print OFENSE 176	HWAY /	ystem he TNN APOUST	NO 21401
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 2 2009 32. Registrar's Signature	back			

	1 - State Registrar	Certificate of	lealth and Mental Hy Death	Reg. No. 2009 32312
Physicia	.ionii Charles Kabosky		2. Date of De Month Septem	3. Time of Death <b>ber</b> 28, 2009 <b>7:00 A</b> M
/Medica Examine Funeral	4a. Facility Name (If not institution, give street and number)  30180 Dudley Road  5. Social Security Number  6. Sex	Mechani (In yrs. last birthday)  If Under 1 Year Months Days		4c. County of Death  St. Mary's  th 9. Birthplace (State or Foreign ay, Year) 13,1927 Cayptry  Taryland
Director show	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Location	Octobe	10d. Inside City Limits
h with the Ma 23a or 28a-fs	Maryland St. Mary's  10e. Street and Number  30180 Dudley Rd.	Mechanicsville  10f. Zip Code  2065	•	1 ☐ Yes 2 😿 No  10g. Citizen of What Country?  USA
15-003(	11. Marital Status  1 Never Married 2 Married  12. Was Decedent E Armed Forces?  1 Never Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 54)	1945 1   1   Yes 2   No	lispanic Origin? (Specify Yes or No an, Mexican, Puerto Rican, etc.) Specify: lation during most of working t)	Specify: White  16b. Kind of Business/Industry
laryland 212. 2 should be filed within and Mental Hygiene. Is marked other than aumatic event, Inc.	17. Father's Name (First, Middle, Last) Henry J. Kabosky	' Electrician	18. Mother's Name (First, Middle Frances E. De	
Mar d 2 sho d 2 sho th and 7 is m traum	19a. Informant's Name/Relationship (Type. Print)  Alice J. Kabosky/Wife	30180 Dudley	Rd., Mechanics	
Baltimore, permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other	20a. Method of Disposition  1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Disposition (Name of cemetery, crematory or other place Queen of Peace Cer	2009	20c. Location - City or Town, State  Helen, MD
Depariment of the control of the con	21. Signature of Funeral Service Licensee  MO  23a. Part1. Enfer the disease, or complications that caused shock, or heart failure. List only one cause on each line	PO Box 128 the death. Do not enter the mode of dvir	, Charlotte Hall	
CB760, tificate be executed as the burial-transit as the burial-transit as the burial-transit as the purial-transit as the purial-tr	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	consequence of):  Consequence of):  Pressure ty  consequence of):	drocephalus	
O. BOX the death certified of the attending	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	2 ☐ Fetal death 3 ☐ Ectopic pregnance	у	23d. Date of delivery Month Day Year
IS, Fres tha	Part II. Other significant conditions contributing to death bu	t not resulting in the underlying cause giv		tobacco use contribute to the cause of death? Yes 2 □ No 3 ☑ Probably 4 □ Unknown
The ate h			24a. Was auto perfi 1 □ Yes	
this this	27. Manner of Death 1 Natural 5 Pending (Month, Day 2 Accident Investigation Sylviside 6 Could not be	<i>Year)</i> Injury Wor M 1 □	y at 28d. Describe K? Yes 2 \[ \sum No	idence 6 □Other (Specify) how injury occurred
DIVISION SEPTIMENT OF SEPTIMENT		f my knowledge, death occurred at the ti	City or To	(Street and Number or Rural Route Number, wn, State) e cause(s) and manner as stated.
be he	29a. Certifier (Check only one)  29b. Signature and title of certifier  29b. Signature and title of certifier	examination and/or investigation, in my	opinion, death occurred at the time	29d. Date signed (Month, Day, Year)  9 - 2 8 - 0 9
State Begistra	CED O U WHAT VA.			

Physician

Examiner

/Medical

Director

Funeral

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Be Completed

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Examine

Be Completed by Physician/Medical

Medical Certification: To

**Examiner** 

For State Registrar				•	•	tificate				ental Hyوا ا	Reg. No.	4UU 5	3	2310
Decedent's Nam	e (First, Midd	le, Last)								2. Date of Dea Month	Day	Year		me of Death
OBERT W	. KNEES	SI, SR.								SEPTEME	BER 1	6 2009		1:45 PM
,		n, give street an	d number)					Location of	of Death			County of Dea	ath	
ALBOT HO			17.	(In t4 t '		EAST(		if Under:	24 Hre 1	8. Date of Birt		LBOT	rthnlaco /	State or Foreign
Social Security No. 19–01–7 Sual Residence of	180	6. Sex 1 <b>X</b> M 2 □		(In yrs. last bir		Months		Hours	Min.	8. Date of Birt (Month, Da 11/25/1	y, Year)	C	rthplace (Sountry)	State or Foreign
a. State	10b. County	,		10c. City, Town										ide City Limits
MD	TALBO	T		ST. MI	CHAE	ILS 10f. Zip	Code	****			10a. Citi	zen of What C	ountry?	
e. Street and Nu		, pp										Lon or Hinat O	outniy:	
084 DRUI	M POINT		Decedent Ev	ver in IIS	12 \//	216		snanic Ori	igin? (Sn	ecify Yes or No	JSA	14. Race - Am	erican Ind	ian.
. Marital Status  1 Never Marital Sid Widowed		rried Arme	decedent Event Eve		If '	Yes, spec	cify Cubar	n, Mexicar	n, Puerto	Rican, etc.)		Black, Whi	te, etc.	19
	15. Deceder	nt's Education est grade comple		16a.		ent's Usua		ation Juring mos	t of worki	ina	16b. Kir	nd of Business	s/Industry	
Elementary/Sec			ge (1-4or 5+	)	life. Do	O NOT us	se retired)	)	. o. work					
12			0-	BID	SPE	CIAL						GOVE	RNMEN	r
7. Father's Name	(First, Middle,	Last)								e (First, Middle,	Maiden	Surname)		
ILLIAM :	KNEESS]	<u> </u>						JOSEI	PHIN	E PROTT				
		ship (Type. Print)	)	19b	Mailing				or or Pur	al Route Numbe	or City o	. T O4-4-	7:- 0-4-	
						,	,							
		NEESSI/W	IFE		84 D	ORUM	POIN	T RD	, ST	. MICHAI	ELS,	MD, 21	1663	
Da. Method of Dis 1 Burial 2 4 □ Donation	sposition ☐ Cremation 5 ☐ Other (5	3 □ Removal f Specify)		20b. Place or cemete.  OLD ST	f Disposi	ORUM ition (Namatory or of	POIN me of other place I'S	e) Og	9/21	. MICHA	ELS, 20c. Lo	MD, 21 cation - City o	L663 r Town, St	ate ND
Da. Method of Dis	sposition ☐ Cremation 5 ☐ Other (5	3 □ Removal f Specify)	rom State	20b. Place or cemete	f Disposi ry, crema L. JC	DRUM ition (Namatory or	POIN me of other place H S and Addres H H	P RD 9	, ST. 9/21, BEIN	MICHAN Date /2009 & NEWN	20c. Lo CORDO	MD, 21 cation - City o  OVA, MA  UNERAL	L663 r Town, Si ARYLA HOME	ate ND
Da. Method of Dis  1 Burial 2  4 Donation  1. Signature of F  3a. Part 1. Enter shock, or he	Sposition  Cremation  5 Other (Suneral Service  The disease, oart failure. Lis	3 ☐ Removal of Specify) Licensee  Frames Arromagnetis on the complications of the complicati	rom State  C. A  hat caused ton each line	20b. Place or cemete.  OLD ST	f Disposi ry, crema 2. JC 22. FEI 200 not enter	NEUM ition (Namatory or	POIN me of other place I S and Addres S, HE HARR de of dying	OS OF FACILITY OF THE CLEAN OF	9/21, by BEIN ST.	MICHANDATE  /2009  & NEWN EASTON	20c. Lo CORDO	MD, 21 cation - City o  OVA, MA  UNERAL	ARYLA  HOME	P.A.  pximate rail Between t and Death
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a. Method of Dis  1 Burial 2  4 Donation  1. Signature of F  3a. Part 1. Enter shock, or he numeriate Cause esease or condition and leave the sease of a condition of the soulting in death)  equentially list or any, leading to in ause. Enter Undause (Disease of at initiated even in the past 12  5 EFEMALE:  3b. Was deceded in the past 12  9 Unknown  CHF  5. Was case refe examiner?	sposition  Cremation  5 Other (Suneral Service  (A) Of the disease, of the dis	3   Removal fispecify) Licensee  Tromplications to only one cause  a. REN Du c. Du d.   23c. If yes 1   4   9   lions contributing	ton State  C. F.  that caused ton each line  CASTAT  e to (or as a  EAL CE  e to (or as a  e to (or as a  e to (or as a  c)  c)  c)  c)  c)  c)  c)  c)  c)  c	20b. Place or cemete.  OLD ST  Che death. Do  Consequence  of pregnancy  Consequence  of pregnancy  Consequence  of pregnancy  The death death  the not resulting in	PRADIO STREET OF	DRUM ition (Name and Action of the Company of the C	POIN me of other place I S and Address S HE HARR de of dying SE  OA Other 28c. Injury Work	e) OS ss of Facilit ELFENI ELSON g, such as	9/21, by BEIN ST, cardiac	**ATCHAD Date /2009  **ANEWN, EASTON or respiratory a  23e. Did t 1 1 2 24a. Was auto, perfo 1 1 Yes th (Check only of	an pay of the pay of t	MD, 21 cation - City of OVA, MA UNERAL, 2160  23d. Date of dight Month  assecontribute XNo 3   1	ARYLA HOME Apprinter Interpretation Appropriate Apprinter Interpretation Interpre	Year  Se of death?  4 Unknown  Unknown  Unknown  Unknown

Letrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated. (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT SMOLOSKI, 609 DUTCHMANS LANE, EASTON, MARYLAND, 21601

31. Date filed (Month, Day, Year) State SEP 2 1 2009 Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend I tem 24a per phys. 6896 9/14/09 dk
State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9/20/2009 Physician/ 11:00 axm Virgil Cline Levelle Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 5343 Sudley Rd. West River 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral **X**IX M 2 □ F Months Days Hours Min (Month, Day, Year) 4/9/1932 235-46-4082 77 WVA **Director** Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits 10c. City. Town or Location with the Maryland ar than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2XX No MD Anne Arundel West River 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5343 Sudley Rd. 20778 USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Race - American Indian Armed Forces?

\*\*Top Yes 2 \sum No Korea
If Yes, Give Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 XXIIIo Specify: White Completed 3 Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Agriculture Farmer injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Thomas Joseph Levelle Regina UNK permit, Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic s 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laurel, MD 20724 Sandy Levelle Daughter 3412 Wenona St. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) James Cemetery 9/25/2009 Lothian, MD 22. Name and Address of Facility Hardesty Funeral Home, P.A. Signature of Funteral/Service License Jahr 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final TRIAL Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner EHAL NOD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examin Cause (Disease or iinjury that initiated events that the death certificate be executed led by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Dav Year Pregnant at time of death 9 Unknown Records, P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen ( 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed Yes 2 this certificate 1 Yes 2 No 25. Was case referred to medical of Vital Hospital or Attending Physician: Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 LXNo ျပ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after ueau..

To the Funeral Director: After th Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 2 Acciden 5 Pending Division 1 Tes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Date signed (Month, Day, Year)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Ye

Dominick Memoli, M.D. 808 Landmark Dr. STE 128 Glen Burnie, MD 21061

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2009

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			1 - For State Registrar	Otato of Mic	ii yiaii	•	tificate of l		-	Reg. No.	JUY	32310
	Physici	an	1. Decedent's Name (First, Middle, Last)  Maria	Leach					2. Date of De Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give s				4b. City. Town, or	Location of Death	321012V	4c. Coun	ty of Death	J= 1000
	Examin	ier	Doctors Hospita	_			•	nham			•	orge's
Т	Funeral		5. Social Security Number 6. Sex		(In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ry, Year)	9. Birthp	lace (State or Foreign
	Director		5/8-66-9654	M ZLAF	60	Yrs.			Jan. 1	9, 1949	Ge:	rmany
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	Mary F-f sh	ţċ	MD Prince Ge	orge's			Во	owie				1 XYes 2 ☐ No
	or 282	Director	10e. Street and Number				10f. Zip Code			10g. Citizen o	f What Coun	itry?
	23a c	ral	12319 Welling Lan	e			207	15			US	A
	er dez	Funeral	The trial of the total of the t	Was Decedent E Armed Forces?		S. 13. V	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14. R	ace - Americ ack, White, e	
36	be filed within 72 hours after death with the Maryland tial Hygiene. d other than "natural", or items 23a or 28a-f show event, if a Modicel Exardiner must be indifficulated.	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ₩ ivorced	1 □Yes 2 🔀 N If Yes, Give Year or Dates:	lo	1	I∐Yes 2X No	Specify:		Spec	ity: Wh	ite
9200-91212	2 hou	ted	15. Decedent's Educ	ation		16a. Deced	lent's Usual Occup	ation		16b. Kind of	Business/Ind	dustry
7	thin 7. e. an "n	Completed	(Specify only highest grade	Completed) College (1-4or 5	+)	1		during most of work d)	ing		utici	
	e filed wi al Hygien I other th vent, It		10			Of	fice Mana			Design		er
yland	be rital	Be	17. Father's Name (First, Middle, Last)  John Pacholkiw					18. Mother's Nam		schmidt		
Ž	s 1 and 2 should be f Health and Ments item 27 is marked other traumatic e	မ	John Pacholkiw  19a. Informant's Name/Relationship (Type)	ne Print)		19h Mailin	n Address (Street	Anna and Number or Rui				Code)
Nar	o, e, a, a		John R. Leach, IV/					rrace, Sy				,
ē,	permit. Pages 1 and 2 Department of Health 8 Important; If item 27 is any injury or other tra		20a. Method of Disposition		20b. P		sition (Name of natory or other place		Date	20c. Location		wn, State
Ē	Page nent c ant; If ury or		1 ☐ Burial 2 🖾 Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State			rematory	- :	/2009	Baltin	nore,	Maryland
Baitimore,	epartr porta ny inje		21. Signature of Funeral Service License	e /		22	. Name and Addre	4.50	eall Fu	neral H	Home	
_	2011		flery			6	512 NW C	rain Hwy.	, Bowie	, MD 20	715	
			23a. 111. Enter the discusse, or complice shock, or heart fail re. List only on	eations ITEI caused e cause on each lin	the death ie.	h. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	rrest,		Approximate Interval Between Onset and Death
7	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		•	onary	Arrest					
· /	Examiner			Due to (or as a			1 T					
		jer	Sequentially list conditions, if any, leaving to immediate	Due to (or as a			l Infarc	cion				
	cuted nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Takot	subc	Cardi	omyopathy	У				
Ď,	e exe ian al urial-t		resulting in death) Last	Due to (or as a	a consequ	uence of):						
6876U,	rificate be executed ng physician and as the burial-transit	ledical	d	Нуре	erlip	pidemia	•					
	certific ding p		IF FEMALE:	3c. If yes, outcome	of preama	ancy				00.15		
X P Q	death ce e attendi d for use	clan	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 🗌 Feta	Ideath 3	Ectopic pregnanc Other (specify)	у			Date of delive Month	Day Year
	t the d by the ached	Physician/IV	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	9 ☐ Unknown								
ν̈́ <del>L</del>	w requires that the death cer been signed by the attendir should be detached for use	by P	Part II. Other significant conditions con	tributing to death bu	ut not resu	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did 1	obacco use co	ontribute to th	he cause of death?
ecora	equire en siç ould b	ed t	Sinusitis						1 🕸	Yes 2 □ No	3 ☐ Prob	oably 4 🗌 Unknown
	10 to 10	Completed	S/P Ovarian Mass						24a. Was	psv I	o. Were auto	psy findings available mpletion of cause of
		Con	Chronic Obstructi	ve Lung D	oisea	ıse			perfo 1 □ Yes	rmed? 2 ⊈No	death?	
VITal	Physician: The land this certificate harral director, page?	Be	25. Was case referred to medical examiner?	ospital:			Oth	26. Place of Deal				
0	Physral di	. To	1 ☐ Yes 2 점 No	1 ☐ Inpatie 28a. Date of Injur		ER/Outpatier 28b. Time of	IL 3 LI DOX	4 Li Nursing no	ome 5 Resi			(y)
VISION	Attending r death. ector: After by the funer	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	í, Year)	Injury	Worl	ḱ? Yes 2 □No	zod. Booonbo	non injury coo		
<u> S</u>	I or Attendi after death. Director: A I in by the fu	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Inju	ry - At ho	ome, farm, stre	eet, factory, office		28f. Location (	Street and Nur	mber or Rura	al Route Number,
5	tal or	Cert	4 Li nomede	Duliging, etc	, (Specif	<i>y</i> /			City or To	wii, State)		
	the Hospital or hin 24 hours afte the Funeral Dir Tpletely filled in I		29a. Certifier (Check only 2 Medical Examir	ician: To the best of	of my kno examina	wledge, death	n occurred at the til	me, date and place	, and due to the	cause(s) and	manner as s	stated.
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical	one)	and manner sta			29c. Licens			29d. Date sign		
	<b>6</b> With		29b. Signature and title of certifier	W				20757	,			
			30. Name and address of person who co	1 nev	ath (Ita-	n 23a) /Tune					15/0	
( )	45		AROOK S. RAO	mpregred values of de	00 /	5001 2	JCK RO	AD 501	TE 305	CAN;	+ Aun,	110 20706
	Sta	to	31. Date filed (Month, Day, Year)	32. Pégistra	ar's Signa	ture						,-0

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year) SEP 22 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 5 per fh 9896 10-15-09
State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar	otato or me	•		tificate of I	Death	, ,	g. No.?	09	32317	1
	Division		1. Decedent's Name (First, Middle, Last	)					2. Date of Death Month	Day	Year	3. Time of Death	-
	Physici /Medic			Robert H	Edward L	awre	ence		Septembe	r Ž1	2009	1:00p M	
and it	Examin		4a. Facility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Death		4c. County	y of Death		
and the	-		5015 Old Bartholov					Airy			Frede		_
	Funeral Director		5. Social Security Number 461 416-47-1842  Usual Residence of Decedent	X 7. Ago XIM 2□ F	(In yrs. last birti	rs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, June 12,	Year) 1978	9. Birthp Coun Tex	olace (State or Foreign htry) KAS	_
	ow #		10a. State 10b. County		10c. City, Town	or Loca	ation				1	0d. Inside City Limits	-
	Mary	ţo	Maryland Frederi	ck	Mt. Ai	rv						1 □Yes 2X No	
	or 282	Director	10e. Street and Number		1101 112		10f. Zip Code		10	g. Citizen of	What Coun	itry?	-
	th wi		5015 Old Bartholow	s Road			217	771		Unit	ed St	ates	
and 21215-0036  be filed within 72 hours after death with the Maryland ntal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the hydical Evanine must be notified at		by Funeral	11. Marital Status  1   Never Married 2   Married 3   Widowed 4   Divorced	12. Was Decedent 8 Armed Forces? 1 ☐ Yes 2 ☒ N If Yes, Give Year or Dates:			as Decedent of H Yes, specify Cuba □Yes 2⊠No	ispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		ce - Americ ack, White, e		
Ö	2 hou	ted	15. Decedent's Edu	cation	16a.	Decede	ent's Usual Occup	ation	14	6b. Kind of E			
21	thin 7 ne. nan "n	Completed	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5	+)	life. Di	ond of work done on NOT use retired	during most of work f)	ring				
2	ed wi tygier her th			1		Ca	regiver	.=		Home H			_
anc	eve d	Be	17. Father's Name (First, Middle, Last)						e (First, Middle, M	aiden Surnai	ne)		
2	2 should be filed and Mental Hygi is marked other aumatic event, II	၉	Unknown  19a. Informant's Name/Relationship (Ty	(ne Print)	196	Mailing	Addrage (Stragt	Martha L and Number or Rui		City or Town	State Zin	Code	_
<u>8</u>			Martha Lawrence/ M	,			·					and 21771	
ē,	es 1 and of Health fitem 27 rother tu		20a. Method of Disposition				tion (Name of atory or other place			Oc. Location			-
Ë	Pages nent of int; If its iry or o		1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)					y Inc.9/2	3/2009	Freder	cick.	Maryland	
Baltimore, Maryland 21215-0036	permit. Pag Department Important; I any injury o		21. Signature of Free eral Service Licens	Men	Deduii	22.	Name and Addres	ss of Facility				yland21771	
			23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or	ications mat caused	the death. Do n							Approximate Interval Between	
1	Physician		Immediate Cause (Final disease or condition	0 1		die	order				/	Onset and Death	
	/Medical Examiner		resulting in death)		a consequence o							-na-o u	
	LAAIIIIIEI	_	Sequentially list conditions,	D		Λ.							_
	ted nsit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter on anying Cause (Disease or injury	Due to (or as	a consequence o	r):					24		
	execun and al-tra	Examiner	that initiated events resulting in death) Last	Due to (or as	a consequence o	f):							-
68760	ficate be executed physician and s the burial-transit	call		d									
9	ertifica ling phy e as th	Medical	IS SERVICE				7.7			1			_
O. Box	death c e attenc d for us	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death		Ectopic pregnanc Other <i>(sp</i> ec <i>ify)</i>	у			ate of delive	ery Day Year	
ds, P.	The law requires that the diate has been signed by the page 2 should be detached		Part II. Other significant conditions con		_		lerlying cause give		23e. Did toba			ne cause of death?	
Ö	v requ	etec	UCHIZOPHICNIA					· · · · · · · · · · · · · · · · · · ·					
Vital Records,	The larate has	Completed by	OF Management and the state of							ed? No	prior to condeath?	psy findings available mpletion of cause of	_
5	/sicia s cert lirecto	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	fospital:	nt 2 ER/Out	nationt	3 🗆 DOA Othe		h <i>(Check only one</i> ome 5 Resider		hor (C4		-
0	ding Physician: n. After this certific funeral director,	Ëä	27. Manner of Death	28a. Date of Injur	y 28b. Ti	me of	28c. Injur		28d. Describe how			<i>y)</i>	-
Ö	ath. Pr: Aff	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day	, rear)	jury		Yes 2 □ No					
DIVISION	To the Hospital or Attending Physician: within 24 hours after death as a feet death. To the Funeral Director: After this certifica completely filled in by the funeral director, to	Certification: To	3 Suicide 6 Could not be determined	28e. Place of Injubulding, etc.		n, stree	et, factory, office		28f. Location (Str. City or Town,	et and Num State)	ber or Rura	l Route Number,	
	he Hospi in 24 hou he Funer pletely fill	edical	29a. Certifier (Check only one) Certifying Phy 2 Medical Exami	sician: To the best oner: On the basis of and manner sta	examination and	death l/or inve	occurred at the tirestigation, in my o	ne, date and place, pinion, death occur	and due to the ca red at the time, da	use(s) and n te and place	nanner as s , and due to	tated. the cause(s)	
	To t	Σ	29b. Signature and title of certifier	_	A -		29c. License			d. Date signe			
			Subare The	risul,	70		DOO	68078	4	- 23	- 20	09	_
			30. Name and address of person who co	ault 1	200 (		,	et, Suite	212A Ga:	ithers	burg	MD 20877	_
	Sta Registr		31. Date filed (Month, Day, Year) SEP 2 4 200	1	ur's Signature	Jan	chal						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Beg. No. 2 0 0 9

		•	For State Registrar	State of Mary	•	irtment of H tificate of D			iene <sub>eg. No.</sub> 20	09	32318		
	Physicia		1. Decedent's Name (First, Middle, Last)  Erma Bowen Morgan			2. Date of Death Month 9 / 2		Year	3. Time of Death 4:30am M				
	Medic Examin		4a. Facility Name (if not institution, give stree Crofton Convalescer			Location of Death		4c. County of Death Anne Arunde1					
	Funeral Director		5. Social Security Number 6. Sex 1 \( \triangle \) 1 \( \triangle \) 1 \( \triangle \) 1 \( \triangle \) 1	yrs. last birthday) 88 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		olace (State or Foreign try) MD				
	and show Lat	or	Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or Loc	cation					0d. Inside City Limits		
	Maryli 28a-f notifiec	Funeral Director	MD Anne Arur	nde1	0de:	nton			1				
	vith the 23a or st be i	ral [	10e. Street and Number			10f. Zip Code Odent	on	1	0g. Citizen of V	vhat Coun USA	itry?		
	eath v tems er mu	Fune	1004 Sunbeam Ct.  11. Marital Status 12.	Was Decedent Ever Armed Forces?	in U.S. 13. V	Vas Decedent of His Yes, specify Cubar	spanic Origin? (Spe	ecify Yes or No-	14. Race	e - Americ	an Indian,		
036	is filed within 72 hours after death with the Maryland tal Hyglene.  ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	1 ☐ Never Married 2 ☐ Married  3★★Widowed 4 ☐ Divorced	1 Yes 2 No If Yes, Give Year or Dates.	1	Yes 2XX No		nicari, etc.)	Specify:	k, White, (	White		
15-0	72 hour in "natu Medical	Completed	15. Decedent's Educa (Specify only highest grade of	completed)	I (Give k	ent's Usual Occupa kind of work done d O NOT use retired)	ation luring most of worki	ing	16b. Kind of Bu	ısiness Ind	dustry		
212	within giene. ier tha t, the !		Elementary/Seconday (0-12) 12	College (1-4 or 5+)		nissions	Dept		State	of Ma	aryland		
and	be filed ental Hy ked oth ic event	To Be	17. Father's Name (First, Middle, Last)  Leland Bowen				18. Mother's Name		faiden Surname	)			
ary	should be file n and Mental   7 is marked o raumatic eve		19a. Informant's Name/Relationship (Type,	19b. Mailin	g Address (Street a		al Route Number, City or Town, State, Zip Code)						
Ž			Marsha Dyjack Da	ughter	1004 S	Sunbeam C		ton, MD		City or To	uun Chata		
mor	Page 1 incent of hint: If its		1 <b>XX</b> Burial 2 ☐ Cremation 3 ☐ Rer 4 ☐ Donation 5 ☐ Other (Specify)	noval from State	cemetery, crem	natory or other place	e)		20c. Location - <b>E1krid</b> g	-			
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once,		21. Signature of Funeral Service Licensee		22	. Name and Addres	s of Facility Han	rdesty F	uneral	Home			
i			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between										
	nysician/ Medical	7 7	Immediate Cause (Final disease or condition and the condition and										
	Examiner		Due to (or as a consequence of):										
	o it	Examiner	Bequentially list conditions, if any, leading to immediate Due to (or as a consequence of):  Cause: Enter Underlying										
	xecute n and al-trans												
09	cate be executed physician and the burial-transit	edical	d. ,				•	<u></u>		_			
(687	certifica anding p use as	an/Me	20b. Was decedent pregnant	. If yes, outcome of p 1 ☐ Live Birth 2 ☐		Ectopic pregnanc	v		23d. Dat	te of deliv	ery		
Box	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours afferd death.  To the Funeral Director Affer this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No g ☐ Unknown	4 Pregnant at tim		y		Мо	nth	Day Year			
s, P.O.	es that t signed b	by	Fact II. Other significant containing to death but not resulting in the discertifing cause given in rate.								ntribute to the cause of death?		
Division of Vital Records,	w requi is been 2 should	Completed	Deuelly 24a. Was an autopsy prior to								psy findings available mpletion of cause of		
Red	The la							perform	ormed? death?				
/ital	sician s certifi	To Be	25. Was case referred to medical examiner?  1  Yes	pital:	2 ☐ EB/Outpation	Othe	ace of Death (Checi		anga 6 🗆 Otho	or /Specifi	A		
of/	ing Phy		27. Manner of Death  1. ■ Natural 5 □ Pending	28a. Date of injury (Month, Day, Ye	28b. Time of								
ision	Attendi er death ector; A by the f	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury -			Yes 2 □ No		Location (Street and Number or Rural Route Number,				
<u>&gt;</u>	oital or urs afte eral Dire												
	ne Hosi in 24 ho he Fune pleted f	Medical	(Check 2 Medical Examiner:	n: To the best of my On the basis of exam ractioner: To the bes	ination and/or invest	igation, in my opinic	on, death occurred a	t the time, date and	d place, and due	e to the ca	use(s) and manner stated.		
_	Veith Com		29b. Signature and tifle of certifier			29c, License		2	9d. Date signed				
			30. Name and address of person who comp	oleted cause of death	ı (Item 23a) (Type, P	rint)	>7028		09-				
(	142		Aditya Chopra	M.D.		dgely /	tvenue:	#231 4	Annapo	115 /	ND 21401		
	Sta Registr		31. Date filed (Month, Day, Year) VSEP 2 2 200	32. Registrar's	Signature	241							

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Dav September 15, 2009

**Physician** /Medical Examiner

Director

Funeral

ģ

Completed

Be

Examine

Physician/Medical

þ

Completed

Be

**Funeral** Director

show in than "natural", or items 23a or 28a-f show 72 hours after "natural", or if is marked other t of Health and Mental Hv Pages 1 permit. Pages 1 Department of H Important: If ite

Baltimore, Maryland 21215-0036

**Physician** /Medical Examiner

law requires that the death certificate be executed physician and s the burial-tran Box 68760. attending p for use as t P.O. signed by the at be detached for Records, , page 2 s has certificate Vital Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certificately filled in by the funeral director. Division of

To the Ewithin 24

Certification: To 24 hours a Medical completely State Registrar

1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 3. Time of Death Joseph Benjamin Messick 11:00P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall Veterans Home Charlotte Hall St. Mary's 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day. Year) Months Days Hours 1 M 2 □ F 579-10-2526 91 March 20,1918 Washington, DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Maryland St. Mary's Charlotte Hall 10e. Street and Number 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 1 1 1 1 1 2 Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Transportation Cab Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ernest Messick Effie Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ray Messick/Son 105 Cornwall Court, La Plata, MD 20646 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) September 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Brinsfield-Echols Crem. 4 ☐ Donation 5 ☐ Other (Specify) 22,2009 Charlotte Hall 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service License ND M00817 PO Box 128, Charlotte Hall,

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PO Box 128, Charlotte Hall, MD 20622 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ros tate Cancer Due to (or as a consequence of): Dysphagia IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Vear Day Pregnant at time of death 5 ☐ Other (specify)

9 Unknown

25. Was case referred to medical examiner?

1 Tes 2 No

27. Manner of Death

1X Natural

2 ☐ Accident

4 Homicide

(Check only one)

FRANCISCA

29b. Signature and title of certifier

3 Suicide

29a, Certifier

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed

HALL

1∐Yes 2. No

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work?

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

1 □Yes 2 □No

CHARLOTTE

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

2**/**€ No 1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

9/16/09

29d. Date signed (Month, Day, Year)

20622

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29449 CHARLOTTE HALL RD

BRUNEY, MD

31. Date filed (Month, Day, Year) SEP 21 2009

5 Pending

investigation



	1 - For State Regis	trar	St	tate of M	larylan	id / Depa <i>Ce</i> a	artmer rtificat				lental Hy	giene Reg. No.	9 11 11	9	323
Physician /Medical	1. Decede	nt's Name (First, Mid Elton	dle, Last) Thòmas	McG	hee					\$	2. Date of De eptemb	ath	3, 2009		Time of Dea
Examiner	145	Name (If not institut 18 Shirle			r)			Mt.	Location Airy				County of Dear		
Funeral Director	227-2	ecurity Number  6-1908  dence of Decedent	6. Sex 1 💢 M		ge (In yrs. 91	last birthday) Yrs.	If Unde Months	1 Year Days	If Under Hours	Min.	8. Date of Bi (Month, D Lugust			untry)	(State or Fo inia
h the Maryland in 28a-f show in title of a show in title of a show in ector	10a. State	10b. Coun	,			t Airy	cation	Code				10g. Cit	izen of What Co	1	nside City Li
ed within 72 hours after death with the Maryland ygiene. In than "natural", or items 23a or 28a-f show t, the Middeal Evan fine, ust be notified at Completed by Funeral Director	14518 11. Marital 1 □ Ne 3 ☑ Wi	Shirley Status ver Married 2 Maddowed 4 Divorce	12. V arried 1	O.a.d Vas Deceden Armed Forces □ Yes 2 K Fyes, Give Year or Dates	? ] No		2]77 Was Dece If Yes, spe	dent of H cify Cuba	ispanic Or In, Mexical Specify	n, Puerto	ecify Yes or N Rican, etc.)	USA -	14. Race - Ame Black, Whit Specify:		dian,
filed within 72 h I Hygiene. other than "natu ent, the Medical ent, the Completee		(Specify only highest grade completed)   (Give kind					kind of wo DO NOT u	ind of work done during most of working O NOT use retired)					tructio	of Business/Industry	
should be f marked of matic eve To Be	Marvi	n Columbu	s McGh			19b Mailii	na Address		Hesba	a Mil	dred Fariss I Route Number, City or Town, State, Zip Code)				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and once.  To Be Completed by Funeral Director	Joan  20a. Metho  1038 4 🗆 Do	Battard, od of Disposition orial 2 Cremation onation 5 N Other ure of Fun Servi	step—da n 3□Remo (Specify)	aughte	20b. F	14518 Place of Disponentery, cres	Shir sition (Name andory or d	ley ne of other place	Bohn	Road	Moun	20c. Lo	ry, Mar ocation - City or t Airy, liams F	ylar Town, S	nd 21 State
ificate be executed  physician and physician and street burial-transit  street burial-transit  et a street	In rediate	Enter the disease, k, or heart failure. Li Causa (Final condition in death)  Ity list conditions, ter Underlying sease or injury dievents ideath) Last	or complications only one care b	Due to (or a	ine. A S C s a consequence a consequence	h. Do not ent  \( \sum \)  uence of):	6101 er the mod	Ridg le of dyir	e R⊖€ g, such as	ad, D s cardiac c	emascu r respiratory	s Ma	aryland	pp	roxi ate roxi Betwee eet and Deat
The law requires that the death certifical ate has been signed by the attending phyage 2 should be detached for use as the completed by Physician/Medicompleted	IF FEMAL 23b. Was in the 1 🗆 Y 9 🗆 L	E: decedent pregnant past 12 months? des 2 □ No Jnknown	1 4	f yes, outcom □ Live birth □ Pregnant □ Unknown	2 🗆 Feta	I death 3	∃Ectopic p ∃Other <i>(s</i> j		у				23d. Date of de Month	livery Day	Year
quires that an signed build be deta		er significant condi	tions contribu	iting to death	but not resi	•	nderlying o	ause giv	en in Part I	l. 		_	use contribute to		
: The law requires t cate has been signe page 2 should be c					· -						24a. Was auto perf 1 □Yes		death?	comple	tion of cause
certifi ector,	25. Was ca examir	ase referred to medic er? s 22No	al Hospi	tal:	☐ Inpatient 2 ☐ ER/Outpatier			26. Place of I			_				
on life	27. Manner of Death  1. Natural 2 Accident 3 Suicide 4 Homicide  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M 1 Yes 2 No  28d. Describe how injury occurred Work? 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred								//	ute Number,					
In othe Hospital or Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu Medical Certificati	29a. Certif (Chec	ier 1 Certify	al Examiner:	n: To the bes On the basis and manners	of examina	wledge, deat tion and/or in	n occurred vestigation	at the til	ne, date a pinion, de	nd place, ath occurr	and due to the	e cause(s	s) and manner a d place, and du	s stated	i. cause(s)
To the within To the compl	•	ture and title of certif	ier fin I	245	ru			_	e number	89			te signed (Monitorial tember		· ·
State	Austin	and address of person 1 Pearre, ed (Month, Day, Yea SEP 2.4	MD, 30	0 West		h Stre		red	erick	. Ma	aryland	l 21	701		

amend #5 tale of Maryland / Department of Health and Mental Hygiene

Amend #26, per ME g901 3/4/10 TT

Reg. No. 1 - State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** Septen 1800 M Joseph Monroe Morris Jr. Jan 16, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 12606 Kemmerton Ln. Prince Georges Bowie If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 07/06/1956 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Hours **№** M 2 🗆 F Months Days DC Director 53 Wash. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Maddoal Examinat misst be notified at 1 ☐ Yes 2 🔀 No Director MD Prince Georges Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with 12606 Kemmerton Ln. 20715 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No
If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: Black 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "nat any injury or other traumatic event, the Medeas once. (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Financial Services Mortgage Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Monroe Morris Sr. Polly Anna Holland 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jean Gale Morris / Wife 12606 Kennerton Ln, Bowie, MD 20715 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Natl.Cem. 09/22/09 Laurel, MD 21. Sign rure of Funeral Service License 22. Name and Address of Facility Universal Mortuary Inc. Kennedy St NW, Washington, DC 20011 411 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician 41050 Dr. Can disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or se's consequence of): The law requires that the death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of): burial Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) signed by the a 1 ☐ Yes 2 ☐ No o 9 Unknown ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? this certificate has al director, page 2: autopsy performe 1 ☐ Yes 2 MNo 1 □Yes 2 □ No **Division of Vital** 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other:  $4 \square$  Nursing Home  $5 \square$  Residence  $6 \cancel{X}$  Other (Specify) at scene 1 Yes 2 No P 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Funeral Director; After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Attending 1-Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide ŏ within 24 hours a To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Date filed (Month, State SEP 2 5 2009 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1 - For State of Maryland / PerPhys. PCC9-25-09cr  1. Decedent's Name (First, Middle, Last)		rtment of H		and M		Reg. No.	200	3. Time of Death	
Physiciar /Medica Examine	al	Ellen F Moore 4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Lanction	of Dooth	Sept.	22	Year 2009 County of Dea	4:43 PM	
Funeral Director	-1	Haran Cont. General Hopital  5. Social Security Number 213-46-9092 1□ M 2♥ F 68	oirthday) . Yrs.	If Under 1 Year Months Days	If Under 2	4	8. Date of Birt (Month, Da June 26	1	9. Bir	rthplace (State or Foreign ountry) andy, VA	
D .	tor		10c. City, Town or Location  Jessup							10d. Inside City Limits 1 □Yes 2 ☒ No	
h with the	Funeral Director	10e. Street and Number 8033 Jenmar Road		10f. Zip Code 207	94				en of What Co	ountry?	
Irs a	2	11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☑ No  If Yes, Give  Year or Dates:		Vas Decedent of H Yes, specify Cuba □Yes 2☑No	ispanic Oric n, Mexican, Specify:	gin? (Spe , Puerto f	cify Yes or No- Rican, etc.)		4. Race - Ame Black, Whit		
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permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, Inc. Monce.	e P	17. Father's Name (First, Middle, Last) Thomas Thornton					(First, Middle, evenge1		Surname)		
s 1 and 2 sho f Health and tem 27 is m other traum				Address (Street a Jenmar Ro						Zip Code)	
Pages 1 ment of H ant: If iter ury or oth		- L Dana L La Oremanon S L nemova nom State		isposition (Name of crematory or other place) Lan Crematory 9/25/2009					20c. Location - City or Town, State Alexandria, Virginia		
permit. Depart Import any inj		21. Signature of Funeral Service Licensee  Claudette Handanina	9 Balt ttsvil	imore Ave. le, MD 2078							
Physician /Medical Examiner BExaminer	Ž	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. List only one cause on each line.  Due to (or as a consequence of):									
Ine law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit completed by Physician/Medical Examir	iyəlci alı ilinedical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
w requires that the speed should be detected by P	2	Part II. Other significant conditions contributing to death but not resulting in Atrical Fibrillation, Pulmonay I	in the und	derlying cause give	n in Part I.			oacco us	_	o the cause of death?	
	Type 2 Oceletes Mellitus 129No								24b. Were autopsy findings available prior to completion of cause of death?  1  Yes 2 No		
ding Phys h. After this funeral di	2	examiner?  1  Yes 2 No A cepte Hospital: 1 inpatient 2 ER/Or  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 6 Could not be determined Homicide  28e. Place of Injury - At home, fa building, etc. (Specify)	26. Place of Death (Check only one)  7. 4 Nursing Home 5 Residence 6 Other (Specify) at 28d. Describe how injury occurred es 2 No  28f. Location (Street and Number or Rural Route Numb								
Hospi 4 hou Funer ely fil		29a. Certifier (Check only one)    Check only one)   Check only on	e, death on	occurred at the timestigation, in my op	e, date and inion, death	place, ar	nd due to the c	21150(5) 5	and manner as	s stated.	
To the Position 2 within 2 To the Formula Complete Media		29b. Signature and title of certifier		29c. License	number		2	9d. Date	signed (Monti	h, Day, Year)	
State Registrar		SEP 2 5 2009	P <sub>2</sub>	hyent	PK	Ewy.	Colo	- 5.	s a	2009	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Mary Morgereth October 4 2009 12:25 am м Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Baltimore Gilchrist Center Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Days Min September 6 1920 219 12 8273 89 Baltimore Co., Md Director Usual Residence of Decedent show 10a, State within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10b. County 10c, City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Baltimore County 1 Yes 2 No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21236 USA 7847 St. Thomas Drive 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 N No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Specify: White Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nould be filed within 72 and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) Housekeeping-Own Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname)
Mary Christ 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be file Department of Health and Mental F Important: If item 27 is marked o Thomas Rohe 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7847 St. Thomas Drive Baltimore, Maryland 21236 John J Morgereth (Husband) Important: If item any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc October 5 2009 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility
Lassann Funeral Home Inc Dotta 7401 Belair Road Baltimore, Maryland 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ Due to (or as a consequence of): disease or condition resulting in death) Medical Examiner linou troct infectu Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed the bunal-transi Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months?

1 Yes 2 No Pregnant at time of death ate has been signed by the a page 2 should be detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Struc hear failur this certificate 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mapner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) est

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Year

Box 68760

P.O.

Division of Vital Records.

3232

			for State Registrar	State of Ma	iryiand		tificate of		i Mental Hy				
T	Discolate	/	1. Decedent's Name (First, Middle, Last)							Reg. No ath		3. Time of Death	
Physician/ Medical Examiner			Anna M			August	30.	2009 Year	2:45 P M				
		er	4a. Facility Name (if not institution, give str	ŕ			4b. City, Town, o	or Location of Dea	ath	4c.	County of Death	erv	
	Funeral		National Lutherar 5. Social Security Number 6. Sex	Home 7. Age	(In yrs. last	birthday)	If Under 1 Year		rs. 8 Date of Bird	th	a Rieth	nplace (State or Foreign	
	Director		131 30 3333	M 2 X F		2 Yrs.	Months Days	Hours Mi	n. A (b) (pmfn, 10a)	Year)	917 Per	nnsylvania	
036	nd how at	Ļ	Usual Residence of Decedent									10d. Inside City Limits	
	/aryla 8a-f s tified	rect	Maryland Montgomery Rockville							1 🗆 Yes 2 💆 No			
	a or 2 be no		10e. Street and Number				10f. Zip Code			10g. Cit	izen of What Cou		
	th with ms 23 must	Funeral Director	9701 Veirs Drive					850		Uni	ted Sta	tes 	
	be filed within 72 hours after death with the Maryland ental Hygiene. ked other than "natural", or items 23a or 28a-f show ic event, the Medical Examiner must be notified at	Completed by Fu	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☒ Widowed 4 ☐ Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates.			/as Decedent of H Yes, specify Cub  ☐ Yes 2		Specify Yes or No- erto Rican, etc.)		14. Race - Ameri Black, White, Specify: Whi	etc.	
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<u>a</u>	ge 1 and 2 should be filed wit nt of Health and Mental Hygie :: If item 27 is marked other or other traumatic event, #		19a. Informant's Name/Relationship (Type, Print)  George Orr, Son  11992 Mojave Lane, Woodbridge, VA 2								Code)		
Baltimore, Maryland 21215-0036	ge 1 and t of Heal If item 3 or other		George Orr, Son 20a. Method of Disposition		20b. Plac	e of Dispos	ition (Name of		Date		ocation - City or To	own. State	
	Page ment c ant: If ury or		1 ☐ Burial 2 🕅 Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	ı	etery, crem Crema	atory`or other pla torv		08/09		odbridge		
Balt	permit. Page Department of Important: If any injury or once.	3	21. Si mature of Fuveral Service Licensee	11010	08	22.	Name and Addre	ss of Facility M	iller Fur d., Woodb	eral	Tome	22192	
			23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	ations that caused to	he death. D							Approximate Interval Between	
W	Physician/ Medical	iner	Immediate Cause (Final disease or condition resulting in death)	Sepsis								Gnsen and Seath	
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	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a o	consequen	ce ot):							
09/80	ficate   g phys	Medic	d.										
DOX OF	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🏋 No 9 ☐ Unknown	. If yes, outcome of 1  Live Birth 2 4  Pregnant at t 9  Unknown	☐ Fetal de	eath 3 🗌	Ectopic pregnand Other (specify)	су		2	23d. Date of delive Month	ery Day Year	
ŗ.	that th	y P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute  Alzheimer's Dementia  1  Yes 2 No 3 Did tobacco use contribute								se contribute to th	ibute to the cause of death?	
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5	ig Phy ter this neral c		1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury 28b. Time of 28					OA 4 LA Nursing Home 5 Residence 28c. Injury at 28d. Describe how					
DIVISION	tendin leath. :or: Aff the fur	ifica	1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	Year) injury work?  M 1 ☐ Yes 2 ☐ No				and a second sec					
	oital or At ous after o ral Direct illed in by	al Certificate:	3 ☐ Sulcicle 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)							28f. Location (Street and Number or Rural Route Number, City or Town, State)			
	e Hosp 24 ho e Fune eleted f	Medical	29a. Certifier 1 X Certifying Physicia (Check 2 Medical Examiner: only one) 3 Certifying Nurse P	On the basis of exar	mination and	d/or investio	ation, in my opinio	on, death occurred	at the time date an	d place	and due to the car	rea(e) and manner stated	
	Nothir vithir oomp		29b. Signature and title of certifier	h		/ wicage, ac	29c. License				e signed (Month, L		
	5		Mel	es U	). Ka	21/4	h	D 21726		Se	ptember	1, 2009	
			30. Name and address of person who comp					le. MD	20850				
	Stat	е	Charles W. Karesh,	32 Registrar's	Signatur	lve,	MOCKYTT						
	Registra		nct 02 2009	Course	p p.	14000							

32328

			1- For Amend Item 8 & State of Maryland / Dep State Registrar 17 WCHD/SH 10/1/09 per FH Ce		lental Hygiei						
	Physicia Medic		1. Decedent's Name (First, Middle, Last)  Mildred Ruth	Paris	2. Date of Death Month	Day Year 3. Time of Death					
	Examir		4a. Facility Name (if not institution, give street and number) Washington County Hospital	4b. City, Town, or Location of Death Hagerstown	2.40.1001	4c. County of Death Washington					
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth 9 / (Month, Day, Yea Sept. 22,	9/2/1922. Birthplace (State or Foreign Country) 2, 1922 Maryland					
	yland •f show ed at	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Lo			10d. Inside City Limits					
	a or 28a- be notifi	al Director		WII 10f. Zip Code	10g.	1 🔣 Yes 2 □ No Citizen of What Country?					
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-0036	ours after ttural", or al Exami	eted by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No	1 ☐ Yes 2 🖾 No Specify:		Black, White, etc.  Specify: White					
21215-0036	within 72 hours after death with the Maryland glene. ier than "natural", or items 23a or 28a-f show ier than "natural" the Medical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Seconday (0-12) College (1-4 or 5+)  12  Home	dent's Usual Occupation kind of work done during most of workin IO NOT use retired) <b>maker</b>	16b	Domo a tria					
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Maryland	12 should Ith and M <b>27 is ma</b> r <b>traumat</b>			ng Address (Street and Number or Rural	Route Number, City	, ,					
Baltimore,	permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, once.		20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State  20b. Place of Disposition cemetery, cremation 3 Removal from State	24 St. Paul Rd., Consistion (Name of matory or other place) en Cemeyery 9/26/	ate 20c	. Location - City or Town, State					
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09	s be execu /sician an	dical Ex	that initiated events resulting in death) Last C. Due to (or as a consequence of):								
9289	certificate nding phy use as the	n/Med	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery					
P.O. Box 687	the death by the atte ached for	hysicia	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year					
ls, P.C	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours atter death.  within 24 hours atter death.  The Funeral Sherctor. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Completed by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the u	1111:01		o use contribute to the cause of death?  2 KNo 3 Probably 4 Unknown					
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Ž	Physic this ce al dire	일	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien		ne_5 Residence	6 ☐ Other (Specify)					
ion o	tending F death. tor: After the funer	Certificate;	27. Manner of Death  Natural 5 Pending 2 Actident Investigation 3 Suicide 6 Could not be	work? M 1 ☐ Yes 2 ☐ No	3d. Describe how inj	ury occurred					
Divis	pital or Al burs after or aral Direc	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  29a. Certifier  29a. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.									
	the Hos ithin 24 hc the Func	Medical	29a. Certifier (Check 2	ligation, in my opinion, death occurred at the time, date and place,	he time, date and pla- and due to the caus	ce, and due to the cause(s) and manner stated. e(s) and manner as stated.					
9	= <b>₹</b> ŏ		· May E. Monly b).	29c. License number  DZ3815	9	Date signed (Month, Day, Year)  1-23-09  1021740					
3H	1-4		30. Name and address of person who completed cause of death (Item 23a) (Type, P. W. L. W.	11/5t, Hagerst	ban, u	1021740					
	Stat Registra	State 31. Date filed Month Car Year Q 2000 32. Rigistrar's Signature									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Edwin Howard Porter Year September 20,2009 1:15 P 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel 1714 Vinevard Trail Annapolis
Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Unde 8. Date of Birth Sept. 02, 1931 Birthplace (State or Foreign Country) Months Days Hours Min 214-28-2735 78 Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland | 1 ☐ Yes 2 ☐ No Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1714 Vineyard Trail 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces of 1 Gyes 2 □ No If Yes, Give Year or Dates: 1951–55 Black, White, etc. 1 ☐ Never Married 2 🙀 Married White 1 ☐Yes 2 ☑ No Specify 3 ☐ Widowed 4 ☐ Divorced Specify 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Elevator Installer Elevator Installation 17. Father's Name (First, Middle, Last)
Edwin Green Porter 18. Mother's Name (First, Middle, Maiden Surname) Margaret Echols 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dorothy Patricia Hofmann/Wife 1714 Vineyard Trail, Annapolis, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4☐ Donation 5 X Other (Specify) Entombrent 9-26-09 Gate of Heaven Cem Silver Spring, Md. 21. Signat in 197 veral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, Md.21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Long years Due to (or as a consoluence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to lor as a consequence of Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 4☐ Pregnant at time of death
9☐ Unknown Month Day Ye ar 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

Completed by

Be

မ

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, it is Medical Evan rest must be multilised at once.

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transi by the a signed b peen has s After this certificate he funeral director, page within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

or Attending Physician: The law requires that the death certificate be executed

To the Hospital

Division of Vital Records, P.O. Box 68760,

15× U State

Registrar

Examiner Physician/Medical Completed by Be 25. Was case referred to medical examiner? Certification: To 27. Manner of Death

Medical

31. Date filed (Month, Day, Year) SEP 2 2 2

1 Yes 2 No

2 Accident

3 ☐ Suicide

29a. Certifier (Check only

29b. Signature a

4 ☐ Homicide

Hospital:

5 ☐ Pending investigation

6 □Could not be

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day, Year)

and manner stated.

nd address of person who completed cause of death (Item 23a) (Type, Print) 132 Hulio

2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

23e. Did tobacco use contribute to the cause of death?

24a. Was an

1 □ Yes

Other: 4 Nursing Home 5 Hesidence 6 Other (Specify)

26. Place of Death (Check only one)

autopsy perform 2 No

28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown

1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

2009

Location (Street and Number or Rural Route Number, City or Town, State)

State of Maryland / Department of Health and Mental Hygiene

		-	For State Of Wa		ertificate of D		Reg.	7000	32327
	Physicia		1. Decedent's Name (First, Middle, Last)  John Prescott				2. Date of Death Month	Day Year	3. Time of Death
1.00	/Medic	al	John Prescott  4a. Facility Name (If not institution, give street and number)		4b. City, Town, or I	ocation of Death	Septembe	18,2009 4c, County of Deatl	
1	Examin	er	Laurel Regional Hospital			urel		Prince Ge	orge's
	Funeral Director			(In yrs. last birthda 85 Yrs.	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye October	9. Birti 28,1923	nplace (State or Foreign untry) Trinidad
	pug "		Usual Residence of Decedent  10a, State 10b, County	10c. City, Town or	Location				10d. Inside City Limits
	Maryla f sho	ro	MD Prince George's	,,	Laurel				1 □Yes 2 No
	r 28a	irec	10e. Street and Number		10f. Zip Code		10g	Citizen of What Co	untry?
	th with	ralD	14200 Laurel Park Drive		207			USA	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show wall highty or other traumatic event, I'm Indical Everiains I must be notified at once.	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent E Armed Forces?  1 Yes 2 Never Married 2 Married It Yes (Give Year or Dates:	ver in U.S. 13	3. Was Decedent of His If Yes, specify Cubar 1 □Yes 2 X No	spanic Origin? (Spe i, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: B1	
2-0	72 ho natur	eted	15. Decedent's Education (Specify only highest grade completed)	(Gi	cedent's Usual Occupa	uring most of worki		o. Kind of Business/	ndustry
121	vithin sne.	Completed by	Elementary/Secondary (0-12) College (1-4or 5-	life	<ul> <li>DO NOT use retired)</li> <li>Mechanic</li> </ul>			Automoti	ve
	filed v Hygir Sther ent, I	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Mai	den Surname)	
Maryland	Aental Aental rked c	To B	John Matthias Prescot	:t		Isabe	lla Pier	re	
lary	2 shou and N is ma auma		19a. Informant's Name/Relationship (Type. Print)		ailing Address (Street a				(ip Code)
e, S	l and Health		Jacqueline Sylvestre/Niece		7 Old Chape			D 20715 c. Location - City or	Town State
Baltimore,	Pages ' tment of h tant: If ite		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	Bayview	sposition (Name of trematory or other place Crematory	9/28	/2009 Ba	ltimore,M	
Bai	permit Depar Impor eny In		21. Signature of Funeral Service Licensee		22. Name and Address		all Funer , Bowie,		
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line	the death. Do not e	enter the mode of dying	g, such as cardiac	or respiratory arrest	,	Approximate Interval Between Onset and Death
-	Physician		resulting in death)		tive Pulmor	nary Dise	ase		
н	/Medical Examiner		Due to (or as a	a consequence of):					
		Jer	Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying	consequence of):					
	ecuted nd transit	Examiner	that initiated events c.						
60,	tificate be executed ig physician end es the burial-transit		resulting in death) Last Due to (or as a	a consequence of):					
68760,	ficate physi s the b	edical	d						
O. Box	death cer e attendin d for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome to 1 □ Live birth to 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	ivery Day Year
σ.	requires that the veen signed by th hould be detache	þ	Part II. Other significant conditions contributing to death but	it not resulting in the	e underlying cause give	n in Part I.			the cause of death?
Division of Vital Records,	v requ been should	Completed					24a. Was an		utopsy findings available
Re	e las has e 2	dmc					autopsy performe	d? prior to death?	completion of cause of 2 □ No
ital		BeC	25. Was case referred to medical			26. Place of Deat	1 ☐ Yes 2 h (Check only one)	SINO   TIMES	2 140
) \( \)	S .⊆ 38		examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatie		tient 3 DOA Othe	4 Li Nursing no		ce 6 ☐ Other (Spe	cify)
o uc	IIng P	inol.	27. Manner of Death 28a. Date of Injur 1 Matural 5 Pending (Month, Da)	ry 28b. Time <i>v, Year)</i> Injur	ry Work	rat ? /es 2 □ No	28d. Describe how	injury occurred	
isio	Attending r death. ector: After by the fune	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e. Place of Inju	ıry - At home, farm,	street, factory, office	res Z 🗆 INO	28f. Location (Stre	et and Number or R	ural Route Number,
<u>≥</u>	al or A s after I Dire	Certification: To	4 ☐ Homicide determined building, etc				City or Town,	State)	
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral.	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	f examination and/o	eath occurred at the tin or investigation, in my op	ne, date and place, pinion, death occur	, and due to the cau red at the time, dat	ise(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the complete	Me	29b. Signature and title of certifier	-	29c. License	number	290	l. Date signed (Moni	th, Day, Year)
					343	378		9/20/20	09
0	112		30. Name and address of person who completed cause of de		<sub>pe, Print)</sub> Rd., Laure	1 MD 205	707		
	H) Sta	te.				T, PED 201			
	Sta Registi		SEP 2 2 2009	ar's Signature	and				

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 9 Lloyd Matthew Pinkney 18 2009 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Hospice of Chesapeake Tate House Lothian 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Anne Arundel 8. Date of Birth (Month, Day, Year 2/4/1943 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 1 M 2□ F Months Days Hours Min. 66 216-40-9453 Washington DC Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Yes 2 No Maryland Anne Arundel Oldenton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2003 Pinecroft Ct 21113 USA 12. Was Decedent Ever in U.S. Armed Forces? 15 Yes 2 No 19 If Yes, Give 1968 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1962 1 ∐Yes 2 **∑**No Specify. Specify. 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self-Employed <u>Truck Driver</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Joseph Lonece Brown <u>Pinkney</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gail Pinkney / Wife 2003 Pinecroft Ct, Oldenton MD 21113 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cem. 9-29-2009 Cheltenham, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA, Aquasco MD 20608 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Mr3762 metassat disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to for as a consequence officause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Day Year 4 Pregnant at time of death 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 2 **X** No 1 □Yes 1 🗆 Yes 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) sergion 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined

/Medical Examiner requires that the death certificate be executed and Box 68760, attending physician P.O. | the à Division of Vital Records, certificate

burial-transit the as for use s been signed to should be deta cate has t After this of funeral dire death.

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

28a-f show

Director

Funeral

à

Completed

Be ည

item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Modical Examinar must be notified at

within 72 hours after

s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 Is marked other than

permit. Pages 1 Department of I-Important: If ite any Injury or ot

**Physician** 

altimore, Maryland 21215-0036

Physician/Medical \$ Completed Be Certification: To

Medical

Examiner

Hospital or Attending Physician: within 24 hours after death

To the Funeral Director: ..

completely filled in by the f

Q 12 76/		
	() Paril	

Registrar

1400 Crain 31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29b. Signature and title

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) was person 1400 (Swin Harry Charles)

and manner stated.

8014

29c. License number 065726

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Cross 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death September 16, 2009 **Physician** 12:35 PM Robert Emmert Rice, Jr. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Laurel Regional Hospital Laurel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 7, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Months Days 1 X M 2 □ F 216-22-1026 1930 West Virginia 79 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any liqury or other traumatic event, the Medical Exercises must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐Yes 2 No Director Prince George's Beltsville 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 20705 USA 11333 Frances St. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Myes 2 □ No If Yes, Give Year or Dates: 1947-51 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief Printing Officer U.S. Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Robert E. Rice, Sr. Anna Catherine Zahn 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11333 Frances Dr. Beltsville, MD 20705 Gladys J. Rice / spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Maryland Veterans Cent 9/21/2009 Cheltenh.

22. Name and Address of Facility Beall Funeral Home Cheltenham, MD 21. Signatury of Funeral Service bicensee 6512 NW Crain Hwy. Bowie, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardio Respiratory Arrest disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Pnuemonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed S/P encephalopathy Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 ☐ Linknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 End Stage Parkinsons, HTN, DM 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Prostate CA, CAD, Increased Lipidemia 24a. Was an autopsy nerform 2X No 1 ☐Yes 2 ☐No 1 □ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: / 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 069 247 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier nas 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mohamed Tourky Laurel Regional Hospital 7300 Van Dusen Rd. Laurel, MD 20707 31. Date filed (Month, Registrar's Signature State 2009 Registrar

DHMH 17 Rev 1/2001

filed within 72 hours after death with ould be f Mental i . Pages 1 and 2 should be thent of Health and Ments tant: If Item 27 is marked other

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

**Physician** /Medical Examiner

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 20, 2009 **Physician** Richard Bisell Rowell, Jr. 8:24 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Hospital Center Cheverly Prince George's 8. Date of Birth (Month, Day, Year)

July 26,1941 Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1**X** M 2□ F Days Hours 577-54-9057 68 Washington, DC Usual Residence of Deceden the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ?7 is marked other than "naturel", or Itema 23a or 28a-f show traumatic event, the Medical Examinar must be notified at 1 Yes 2 No Director Maryland ST. Mary's Mechanicsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27275 Morganza Turner Road 20659 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes, 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes A No Specify: White 3 Widowed 4 Oivorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Master Plumber Plumbing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Richard B. Rowell, Sr. Margaret F. Robertson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret McKinney/Sister 27275 Morganza Turner Rd., Mechanicsville, MD 20659 20a. Method of Disposition

1 Burial 2 Fremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date September permit. Page Department of Important: If any injury or ance. Brinsfield-Echols Crem. 4 ☐ Donation 5 ☐ Other (Specify) 23, 2009 Charlotte Hall, MD 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., 21. Signature of Funeral Service Licensee 30195 Three Notch Rd., Charlotte Hall, MD 20622 MO0817 Part1. Enter thildisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death UMNOUS CEM ARCHNONA LUNG pue to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 DEctopic pregnancy 1 Live birth 2 ☐ Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRUNICOUST UCTURE VING 1 Stage 1 TYPES 2 NO 3 Probably 4 QUINKNOWN ENCEPHALOPATY Completed CORONAMY ANTEN 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending death. M 1 Tes 2 No 2 Accident investigation the Director 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) September 20,2008 DO1852

State Registrar

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

reensbury Rd Hygtroville MD 20181

completed cause of death (Item 23a) (Type, Print)

			For	State of Maryland			Mental Hyg	iene	00001
			State Ragistrar		Certificat	e of Death		eg. No. UUS	32331
	Physicia	an	Decedent's Name (First, Middle, Last)	0 1	11.2		2. Date of Dea Month	Day Yeer	3. Time of Death
	/Medic	al	Elizabeth  4a. Fecility Name (If not institution, give s	Rober		Town, or Location of Deatl	09	17 2009 4c. County of Death	604AM
	Examin Funeral Director	er	Prince Ceorges m 5. Social Security Number 6. Sex	redical Center	r Ch	everly 1 Year If Unger 24 Hrs.		Prince Go	lace (State or Foreign
	pu ,		Usual Residence of Decedent  10a. State 10b. County	100 City 1	Town or Location			/	0d. Inside City Limits
	death with the Maryland ima 23a or 28a-f ehow r muat be coulled at	'n	m 1			1.		'	1. Yes 2 No
	28a-f	Director	10e. Street and Number	Anne G	rason Vil	Code	1	log. Citizen of What Coun	stry?
	3a or		323 Sawmil	lane		21638		115A	,
	death	Funeral		12. Was Decedent Ever in U.S. Armed Forces?	13. Was Dece	dent of Hispanic Origin? (S cify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Americ Black, White,	
36	be filed within 72 hours after death with the Marylan ital Hygiene. Id other then "naturel", or Itema 23a or 28a-f ehow event, Ita Medical Evantiner must be notified at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	1 🗆 Yes		o riioari, oto.,	Specify:	51C.
9	2 hour		15. Decedent's Educ	cation 1	16a. Decedent's Usua	al Occupation		16b. Kind of Business/Inc	ack dustry
21215-0036	within 72 ene. then "nat	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT u	ork done during most of wor se retired)	rking		,
	ygiene ygiene er th	Соп	12		Line	Worker		Seatood	
Maryland	be fill hall Hy doth	Be	17. Father's Name (First, Middle, Last)	01		18. Mother's Nar	ne (First, Middle,	0	
2	s 1 end 2 should be f Health and Mental item 27 is marked other treumatic ev	T L	Herman Her  19a. Informant's Name/Relationship (Type	ry Kober	19h Mailing Address	(Street and Number or Ru	ha L,	CONYER CITY OF TOWN STATE ZIO	
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ē,	of Healt of Healt litem 2		20a. Method of Disposition	20b. Plac	ce of Disposition (Nar	m.   Lane,	Date	20c. Location - City or To	own, State
Ē	nit. Pages vartment of l ortant: if it injury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Bonation 5 ☐ Other (Specify)						
Baltimore	permit. Page Department of Important: if any injury or once.		21. Signature of Funeral Service License	2110	22. Name ar	ory LLC 09-	ennie Si	nith Funer	el Home
_	₹0 E € Ø		assial =	ghan	426 0	over St. Eas	ton, mar	yland Z	1601
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.	4.4		or respiratory arr	espr,	Approximate Interval Between Onset and Death
Y	Physician /Medical		disease or condition resulting in death)	Due to (or as a consequen	Arryth	mia			
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687	tificate ng phys as the	edicai	d	Colonary	/ / / / ()	1 + 1500			
Box	eath certif	N/W	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy 1□Live birth 2□Fetal de		· ·		23d. Date of delive	ery
.O. B	e deat	Physician/Me	in the past 12 months? 1 □ Yes 2 ▼No 9 □ Unknown	4 Pregnant at time of death				Month	Day Year
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Division of Vital Record	or Attend after death Director: /	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home building, etc. (Specify)	e, farm, street, factor	y, office	28f. Location (S City or Tow	treet and Number or Rura n. State)	I Route Number,
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	To the Hospitel or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examir	sician: To the best of my knowle ner: On the basis of examination and manner stated.	edge, death occurred n and/or investigation	at the time, date and place i, in my opinion, death occu	e, and due to the durred at the time, o	ause(s) and manner as s date and place, and due to	tated. o the cause(s)
	To th within To th compl	Me	29b. Signature and title of certifier		29	c. License number	2	29d. Date signed (Month,	Day, Year)
	TLS		· glech f.	Ellen -		D27577	7	9/18/0	9
	2		30. Name and address of person who co	mpleted cause of death (Item 2:	3a) (Type, Print)	<u></u>			
			OPHNell Cumber 31 Date filed (Month Day Year)	-batch M.D. 30 32/Registrar's Signature	ol Hospit	al Dr., Chei	verly, M	ary land 2	20784
	Sta Registr		31. Date filed (Month, Day, Year) SEP 21 200	9 Lemma B.	park			•	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amended#16 = State 22,18,/FH, TCHD/9/22/09, Dicertificate of Death 10220 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Physician Month 8:36 M Carol Ann Reid 09 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Berlin Atlantic General Worcester 9. Birthplace (State or Foreign Country)
Salisbury MD Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 🔀 🛠 39 Director 222-66-1856 10 - 24 - 69Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examinat must be notified at Sussex XIX Yes 2 No Director DE Selbyville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 19975 32114 Trapp Lane Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 □ Yes 2 □ Ne 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. 11. Marital Status 0 XXNever Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2/ONNo Specify. ģ If Yes. Give Specify: Black 3 Widowed 4 Divorced Year or Dates: "natural" Completed marked other than "natu 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Work for DOC Elementary/Secondary (0-12) College (1-4or 5+) \*\*eworked for DOC Secretary 12±h 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be f nent of Health and Mental Annabell Showell Percy Reid ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Annabell Reid/Mother 32114 Trapp Lane Selbyville DE. 19973 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If ite any injury or ot once. Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-23-09 Curtis UM Church Bishopville MD. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Seaford, De JATERY ) Young & McPherson F.H. Seaford 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) ULMONARY SEVER AL MINS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Exami attending physician and for use as the burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month 5 Other (specify) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen s 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐Yes 2 ☐No 1 □ Yes 2 NO Division of Vital funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ☐ No Certification: To 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide

State

DOB 10/24/1969

Registrar DHMH 17 Rev 1/2001 29a, Certifier

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifie

Medical

and manner stated.

ZINORTH

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ Shifler William Charles Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington County Hospital Hagerstown Washington Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Age (In yrs. last birthday) Days Hours (Month Day, Min. 215-36-6331 76 Marvland Director Mav Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💢 No Maryland Washington Boonsboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20001 Mill Point Road 21713 U.S.A. death \ 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc "natural", or 1 Never Married 2 XMarried \$ Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 Widowed 4 Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Laboratory Technician Federal Government other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellen Mae Shirley S. Shifler Easterday 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21713 Shirley L. Shifler / Spouse 20001 Mill Point Road Boonsboro, Maryland Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State injury or Boonsboro Cemetery 09/28/2009 Boonsboro, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature Funeral & rvice Ligerse <sup>22. Name and Address of Facility</sup> Bast-Stauffer Funeral Home, P.A. any 7606 Old National Pike 21713 Boonsboro. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Directo for as a nonsequence of if bily leading to knowledge cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death been signed by the a should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy death? 2 No 1 🗌 Yes Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 욘 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 27. Manner of Deat 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 Yes 2 🗆 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1H-V STOWN 31. Date filed (Montise State

Registrar

			For State Registrar	State of Ma	aryland		artmeni rtificate			and M		giene Reg. No	100	10	32	331
			Decedent's Name (First, Middle, Last	st)							2. Date of Dea	ath			3. Time o	f Death
	Physici /Medic		Raymond Joseph S	Schaefer							Month Septen	nber	16,2	009	2:	20P <sup>M</sup>
1	Examin		4a. Facility Name (If not institution, give				4b. City,	Town, or	Location of	of Death			. County of	_		
			Charlotte Hall V				Charlotte Hall						- Family			
	Funeral		5. Social Security Number 6. S	ex 7. Age	90	ast birthday) Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da	y, Year)		Count	-	or Foreign
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	show		10a. State 10b. County		10c. City	, Town or Lo	cation							10	d. Inside C	*
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	or 28	Oire	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of Wh	at Count	ry?	
	23a	Funeral Director	709 Deep Ridge Ro	pad				014				US				
	tems ref	nue	11. Marital Status	12. Was Decedent I Armed Forces? 1 XYes 2 □ N		3. 13.	Was Deced If Yes, spec	ent of H ify Cuba	ispanic Ori an, Mexican	igin? (Spe 1, Puerto l	ecify Yes or No- Rican, etc.)	-	14. Race - Black,	America White, e		
36	", or I	y F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	NO	1 ☐Yes 2 XNo Specify:					Specify:			W	White		
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Maryland	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, The Maonee.		19a. Informant's Name/Relationship ( Kathleen Schaefer		Daugh						., Be1					
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Baltimore,	ages ent of nt: If i		1 ☐ Burial 2 【XCremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif			nsfie:					8, 2009		harlo	tte	На11.	MD
alti.	mit. F partm portar Injui		21. Signature of Fungral Service Liger								isnfiel					
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	/Medical		resulting in death)	Due to (or as		ence of):										
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. B	Phystcian: The law requires that the death certificate that been signed by the attending ratificate that been signed by the attending ratificator, page 2 should be detached for use as	Physician/Me	in the past 12 months? 1 □Yes 2 □No	4 ☐ Pregnant a			Other (sp		·y				Mont	h	Day	Year
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S,	res th signed be de		Part ii. Other significant conditions of	/		0 2 + -		ause giv	en in Part i	•	1 D		. /		ably 4□	
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360	e law has b	g	10 Lung ca	1p Rad	10170	<u> </u>					24a. Was autor		pri	ere autor or to cor ath?	psy finding npletion of	cause of
al	slclan: The certificate h rector, page										1 □Yes	2 <b>/SI</b> N		Yes	2 XNo	
of Vital	s <b>icla</b> certii recto	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:		5D/O 1		Oth			(Check only o		0 DO#			
of	ding Phys h. After this funeral dir	15	27. Manner of Death	28a. Date of Inju	ry	ER/Outpatier 28b. Time o		8c. injur	y at		me 5 Resi				y)	
ion	nding th: :: Afte	tio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	y, Year)	Injury	М	Worl	k?  Yes 2□	No						
Division	r Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		ury - At ho	me, farm, str	eet, factory	, office			28f. Location (.	Street a	ind Number	or Rura	l Route Nu	mber,
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	To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fune.		(Check only 2 Medical Exar	nysician: To the best miner: On the basis of	f examinat											(s)
	thin 2 the complet	Medical	29b. Signature and title of certifier	and manner st	ated.		290	. Licens	e number			29d. D	ate signed	(Month,	Day, Year)	
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(	V.		30. Name and address of person who	completed cause of o		23a) (Type	Print)	- 0	16 701	7		/	. //-/			
6	2x1		Facility Parker		29449		ARLOTTE	H	all R	D	CHARLO	TE	HALL	MA	200	622
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DHMH 17 Rev 1/2001

			1 - State of Ma Registrar	-	partment of H <i>ertificate of L</i>		ental Hygier Reg.		20005
	Physici	an	1. Decedent's Name (First, Middle, Last)  Ethel M. Shank				2. Date of Death Month eptember	22, 2ď69	3. Time of Death 10:45 P.M
-	/Medio		4a. Facility Name (If not institution, give street and number)  Glade Valley Nursing 1		4b. City, Town, or	Location of Death		4c. County of Death	1
	Funeral		5. Social Security Number 6. Sex 7. Age	nome je (In yrs. last birthda	Walkers  If Under 1 Year	If Under 24 Hrs	8. Date of Birth	Frederic	nplace (State or Foreign
	Director		220-30-9575 1	75 Yrs.	Months Days	Hours Will.	(Month, Day, Yea	1934 M	aryland
	show	-C	10a. State 10b. County  Maryland Frederick	10c. City, Town or Freder					10d. Inside City Limits  1224 es 2 □ No
	or 28a-f	Direct	10e. Street and Number		10f. Zip Code	701	10g.	Citizen of What Cou	untry?
	72 hours after death with the Maryland natural", or items 23a or 23a-f show liteal Exercines out by mottled	Funeral Director	313 E. 9th Street  11. Marital Status 12. Was Decedent Armed Forces?	Ever in U.S. 13	3. Was Decedent of His If Yes, specify Cubar		cify Yes or No-	14. Race - Amer Black, White	
900	ours afte ral", or it Exercio	by	1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 🏝 No	Specify:		Specify:	White
1215-(	within 72 h ene. <b>than "natu</b> ne Medeal	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5	(Giv life	cedent's Usual Occupa ve kind of work done d b. DO NOT use retired) emaker	ation luring most of working )	g 16b.	. Kind of Business/I	·
land 2	ld be filed lental Hygi ked other ic event, l	To Be Co	17. Father's Name (First, Middle, Last) unknown	110 1110		18. Mother's Name Cather	(First, Middle, Maid	,	
Mary	ind 2 shou alth and M 27 is mar er traumat		19a. Informant's Name/Relationship (Type. Print) Roy Shank – husband		illing Address (Street a				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Madical Even in a mar be notified at once.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place of Dis cemetery, cr Utica Ce	position (Name of rematory or other place emetery	9-28-2		Location - City or Trederick,	Fown, State Maryland
Balt	permit. Depart Import any Inj		21. Signature of Funeral Service Licensee	///	22. Name and Addres	SLa		neral Hom rick, Mar	
,	hitrate be executed by physician and hysician and Examinetransit the burial-transit	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	ne.	sculor				interval Between Onset and Death
O. Box	requires that the death certificat been signed by the attending phy hould be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/		23d. Date of deli Month	very Day Year
ds, P.	w requires that s been signed b should be deta	þ	Part II. Other significant conditions contributing to death be	ut not resulting in the	underlying cause give	en in Part I.	23e. Did tobacc		the cause of death?
	aw as t	Completed					24a. Was an autopsy performed	prior to death?	topsy findings available completion of cause of
Vita	Physician: r this certific ral director, I	Be	25. Was case referred to medical examiner?  1 ☐ Yes No Hospital: 1 ☐ Inpatie	ent 2 ☐ ER/Outpat	ient 3 DOA Othe	26. Place of Death		6 ☐ Other (Spec	nife()
on of	ding Phy h. After thi funeral c	tion: To	27, Manner of Death  1 Natural 5 Pending  28a. Date of Inju (Month, Da	ury 28b. Time	e of 28c. Injury Work		8d. Describe how in		ony)
Divisi	To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Inju	ury - At home, farm, s c. (Specify)			8f. Location (Street City or Town, St	and Number or Ru ate)	ral Route Number,
	e Hospital 124 hours a e Funeral detely filled	Medical C	29a. Certifier (Check only one)  Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner sta	of examination and/or	eath occurred at the tim r investigation, in my op	ne, date and place, a pinion, death occurre	and due to the caused at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier		29c. License	51643	29d.	Date signed (Month	n, Day, Year)
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DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** Ella S. Smith Ам 2:28 September 19, 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, **Funeral** Days Hours 1 □ M 2 😾 F 91 579-26-4632 Director July2, 1918 Washington, DC Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show r than "natural", or items 23a or 28a-f shov the Modical Examiner must be notified at Prince George's 1 √ Yes 2 No Director Hyattsville 10e. Street and Number 10g. Citizen of What Country? 20782 4907 Eastern Avenue, #203 USA Funeral hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married □Yes 2 No Baltimore, Maryland 21215-0036 **Black** If Yes, Give Year or Dates 1 ☐ Yes 2 🛣 No 2 Specify: 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 h and Mental Hygiene. 7 is marked other than "n Elementary/Secondary (0-12) 1.2 th College (1-4or 5+) Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If item 27 is marked oth any Injury or other traumatic event Be Bessie Green Richard W. Small ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4907 Eastern Avenue, #5, Hyattsville, Md 20782 Gloria S. Richardson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 09-30-2009 Washington, DC Glenwood Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Johnson & Jenkins Funeral Home 716 Kennedy Street, NW, Washington, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) PERTE and burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) physician at the burial P.O. Box 68760, Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 Other (specify) ed by the a ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an 1 □Yes Division of Vital 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐Yes 2⊠No မ 1 ☐ Inpatient 2 ☑ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred al or Attending Is after death. 1 X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral Di Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examíner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number Name and address of person who completed cause of death (Item 23a) (Type, Print) GREENBELT MARYLAND 2017 +325AHAMOVER State

DHMH 17 Rev 1/2001

Registra

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Stephan Nino Tchamouroff 1:30 15, рм 2009 September 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Bowie Health Center Bowie Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) Months Days Hours Min 15 M 2 F March 20,1938 146-48-4357 Israel Usual Residence of Decedent 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location 1XYes 2 No Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2902 Belair Dr. 20715 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates Specify. Specify: 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Music Teacher Music Art Center 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Deshka N. Tsonkov Nino Tchamouroff 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martha Esther Tchamouroff/wife 2902 Belair Dr. Bowie, MD 20715 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 XOther (Specify) entombment Fort Lincoln Cemetery 9/18/2009 Brentwood, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Beall Funeral Home enia Bowie, MD 6512 NW Crain Hwy. 23a. Part1. Enter the divease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart shure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final dd rdiac disease or condition resulting in death) if any, leading to immediate cause. Enter Underlying Cause (Disease or injury onar that initiated events resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) TYes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perforn 2 🗆 No 1 ☐ Yes 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DCA 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred

/Medical Examiner burial-trar physician pe the use as or detached ned by sign be

page 2 s certificate director, this funeral After

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

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and Mental Hygiene.

Department of Health ar Important: If item 27 is any injury or other trau

**Physician** 

Pages '

Baltimore, Maryland 21215-0036

Director

Funeral

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Physician/Medical Completed by Be

Medical Certification: To

Examiner

68760 Box O. σ. Records, Vital or Attending Physician: of Division

death.

within 24 hours a

filled in by the after death

completely

2 Accident

3 ☐ Suicide

29a. Certifier

4 Homicide

5 Pending investigation

6 ☐ Could not be

determined

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

2 🗌 No

1 🗆 Yes

225 E Defense Hwy, Crofton Mazing o completed cause of death (Item 23a) (Type, Print) me 4 2

State Registrar 31. Date filed (Month, Day 2

29b. Signature and till of certifu

Kegistrar's Signatu

and manner stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 1:22 PM 21-2009 e9 -Virginia Lee Travis /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Wicomica the Lake Salisbur castal Hospice at If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🌣 F 218-12-1806 **Director** 23,1923 Maryland June Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, The Maryland Evancher Transi to natified at anones. 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 □Yes 2 No Director MD Wicomico Salisbury 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 1414 Camden Avenue 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐Yes 2 If Yes, Give 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify ģ 3 → Widowed 4 Divorced White Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Salesperson</u> Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Frank Virginia 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Travis- Son 1414 Camden Avenue Salisbury, MD 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cape Charles Cem. 19/25/2009 | Cape Charles, VA 22. Name and Address of Facility Bounds Funeral Home 21. Signature of Fup fal Service Licensee 705 E Main St. Salisbury, MD 21804 23a. P. 1. Enter the disease, or c. m. lications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** BMBN TIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) certificate has been signed by the a rector, page 2 should be detached to 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 91 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes → No 24a. Was an 1 □Yes 2 □No Hospital or Attending Physician: the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Content (Specify) 1 Yes ♣ No HOSPICE 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28b. Time of 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No after death 2 Accident 3 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide e Funeral I CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

WAN

~ Helan

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			For	State of Maryland / De	•		ental Hygie	ne	
_			1 - State Registrar		ertificate of	Death	Reg.	No. 9 0 0	1 2022
	Dhuaisi		1. Decedent's Name (First, Middle, Last)				Date of Death     Month	Day Year	3. Time of Death
	Physici /Medio		James Claude	Vallandingham		2	Month September	26,2009	7:21A M
	Examin		4a. Facility Name (If not institution, give	•		r Location of Death		4c. County of Deatl	n
			12857 Owens Drive		Waldo	rf		Char1e	S
	Funeral		5. Social Security Number 6. Sec	IM all E	Months   Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye	ar) 9. Birti	nplace (State or Foreign untry)
	Director		218-30-3593	80 Yrs			July 7, 1	929	Maryland
	w w		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or	Location				10d. Inside City Limits
	laryli sho	ō							1 □ Yes 2 CXNo
	the N	ect	Maryland   Charles  10e. Street and Number	Wald	orf 10f. Zip Code		100	Citizen of What Co	
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36	rs af	by I	3 Widowed 4 Divorced	If Yes, Give Year or Dates:	1 □Yes 2 MaNo	Specify:		Specify:	Thite
ŏ	72 hours after death with the Maryland 'natural', or items 23a or 28a-f show dical Expriner rust be in affied at	ed	15. Decedent's Educ		cedent's Usual Occup	pation	16b	. Kind of Business/I	
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ar.	2 should be filed within 72 hours after deal and Mental Hygiene. Is marked other than "natural", or items:	-	19a. Informant's Name/Relationship (Ty)		ailing Address (Street			ty or Town, State, Z	(ip Code)
Š	1 and 2 Health a em 27 is		Ida E. Vallanding		57 Owens D				,
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any injury or other traumatic event; the M-citical Expriner roust by muffled at once.	- 7	20a. Method of Disposition	20b. Place of Di	sposition (Name of rematory or other place	Da	ate 20c	. Location - City or 1	Fown, State
e E	Pages nent of hint: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		i	/2000	M 1 -	Od have MD
≣	permit. Page Department of Important: If any Injury or once.	- 3	21. Signature of Funeral Service License		Episcopal			. Mary's	City, MD
Ba	permi Depar Impor any Ir		Shawn Ayleswort	DIAN	Brinsiiel				00650
			23a. Part 1. Enter the disease, or compli		enter the mode of dvi	1ywood Roa	r respiratory arrest.	cdrown, MD	
	Di1.1.	3 3	shock, or heart failure. List only or Immediate Cause (Final	e cause on each line.			,,		Approximate Interval Between Onset and Dean
	Physician /Medical		disease or condition resulting in death)	. lug Co	ucen	ous		10	veonly
4	Examiner			Due to (or as a consequence of):	Olach.	t	Vana	Dage	40000
		ē	Sequentially list conditions,	. Due to (or as a consequence of).	5 62 CC	cc le oq	coup	succe.	Took 5
	nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (01 00 0 001100 01).			ر		$\supset$
	e be executed sician and burial-transit	Xai	that initiated events resulting in death) Last	Due to (or as a consequence of):					
09,	siciar burit							i	
<b>687</b>	The law requires that the death certificate is the has been signed by the attending physioage 2 should be detached for use as the teacher.	Physician/Medical	d						
Box	certi nding use a	Š	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy				23d. Date of deli	verv
	leath cer attendir I for use	cial	in the past 12 months?		3 □ Ectopic pregnand 5 □ Other <i>(specify)</i> _	У		Month	Day Year
Ö	at the de by the tached	ysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗆 Unknown					
σ.	that red b deta		Part II. Other significant conditions con	tributing to death but not resulting in the	underlying cause giv	en in Part I.	23e. Did tobaco	co use contribute to	the cause of death?
ds	uires n sign d be	d by	12 he ame t	and Anth	sti		1 □ Yes	2 □ No 3 □ Pro	obably 4 LUnknown
Ö	w require been si should t	Completed						T	
3e(	e law has je 2 s	ď					24a. Was an autopsy	nrior to o	topsy findings available completion of cause of
<u>=</u>							performed 1 □ Yes 2 ☑	? death? No 1 ☐ Yes	2  No
of Vital Records,	Physician: T this certificat ral director, pa	Be	25. Was case referred to medical examiner?	ospital:	046	26. Place of Death			
of	this aldii	2	1 les 2-110	1 ☐ Inpatient 2 ☐ ER/Outpa		4 LI Nursing Hor		6 ☐ Other (Spec	oify)
E C	ding I h. After funer	ion	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year) 28b. Time Injur	y Wor		8d. Describe how in	njury occurred	
isic	ttend death stor: / the /	icat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	290 Place of Injury At home	l	Yes 2 □No	06 1		
Division	or Attending F after death. I Director: After d in by the funera	ertification:	4 ☐ Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, ractory, office	2	8f. Location (Stree: City or Town, Si	t and Number or Ru tate)	rai Houte Number,

To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the Medical Certific

29b. Signature and title of certifier 29d. Date signed (Month) Day, Year)

9 28 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR ALIKEIAN, 101 Centernal 81. Le Plata, MD 20646 31. Date filed (Month, Day,

12 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

29a. Certifier (Check only one)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** ADRIENNE OCTOBER 12:20a<sup>M</sup> 2009 WILLIS VICKERS 4 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Chestertown

| Funder 1 Year | | Funder 24 Hrs. | 8. Date of Birth (Month, Day, (Month, Day, April 1) Chestertown Nursing & Rehab Kent Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**K** F Maryland April 1915 220-09-6092 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State If item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, I'm Medical Examinar must by notlined at 1 XYes 2 No **Funeral Director** MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 132 Clipper Way 21620 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: White þ 3X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Telephone Company 12 Instructor -Supervisor purmit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if item 27 is marked othr any injury or other traumatic event one. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Van Willis 2 Nettie Blanche Bryan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Vickers 8550 Bell Rose Lane (son) Chestertown, MD 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State Kent Cremation 10/5/09 Smyrna, DE. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Galena Funeral Home of Stephen L Schaech of Funeral Servi M00510 118 West Cross St. Galena, MD. 21635 23a. Part . Entertine disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician t/z/re/mers disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the aftending physician and neral Director: After this certificate has been signed by the aftending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 No P.0. Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 2 🗆 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □Yes 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Neil Stoddard, M.D. 100 Brown St. Chestertown, MD. 21620 31. Date filed (Month State Registrar

DHMH 17 Rev 1/2001

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 26, 2009 2:30 AM Sept Gary L. Wirt 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Hagerstown Washington NMS Healthcare of Hagerstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number Days Months 1**☑** M 2□ F Hours 56 New York 107-44-3052 Feb. 19. Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County 1 ☐ Yes 2 ▼No Hagerstown Washington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21742 14014 Marsh Pike Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. ☐ Yes 2 🛛 No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White 3 ☐ Widowed 4 ☑ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) N/A12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lockwood Laura Kenneth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 702 Fair Winds Dr. Nokomis, FL 34275 Kenneth Wirt / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 9/28/2009 Cumberland, MD Cumberland Crematorium 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gerald N. Minnich Funeral Home 21. Signature of Funeral Service Licenses <u>305 N. Potomac St. Hagerstown, MD 21740</u> 23a. Part1. Enter the disease, or coshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

**Physician** /Medical Examiner

and

attending physician for use as the buria

**Physician** 

/Medical

Examiner

**Funeral** 

Director

show

ems 23a or 28a-f sh r must be notified a

Items 23a

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"natural";

f Health and Mental Hygiene. item 27 Is marked other thar other traumatic event, the M

permit. Pages 1
Department of F
Important: If ite
any injury or ot

Director

Funeral

by

Completed

Be

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the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

Examine

23b. Was decedent pregnant

in the past 12 months?

☐Yes 2☐No

9 Unknown

mplicat	tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line.	Approximate Interval Between Onset and Death
а	Cerebrovascular accident flemosibilic inva	la imonth
7	Due to (or as a consequence of):	
h	Chronic obstructive primary diserie	
J. =	Due to (or as a consequence of):	
U	Due to (or as a consequence of):	
- a		-
23c	. If yes, outcome pf pregnancy . 23d. Date of de	liven
200.	1 Live birth 2 Fetal death 3 Ectopic pregnancy	Dav Year

Physician/Medical þ

the Hospital or Attending Physician: The law requires that the death certificate be executed

after death

Division or Vital Records, P.O. Box 68760

5							
ombien					24a. Was an autopsy performed? 1  Yes 2 No	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No	
200	25. Was case referred to medical examiner? 1 ☐ Yes	Hospital: 1 ☐ Inpatient 2 ☐	]ER/Outpatient 3∏ [	l out	ath <i>(Check only one)</i> Home 5 ☐ Residence 6	3 □Other (Specify)	
ation:	27. Manner of Death Natural 5 Pending 2 Accident investigation		28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	<del></del>	
Sel min	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		ome, farm, street, factory)	28f. Location (Street and Number or Rural Route Number City or Town, State)			

5 ☐ Other (specify)

To the Hospital within 24 hours at To the Funeral C

Medical

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

29b. Signature and title of certifier

4☐Pregnant at time of death

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9☐Unknown

Name and address of person who completed cause of death (Item 23a) (Type, Print)

9/28/01 geath (Item 23a) (Type, Print)
CRUP 14014 Mish Pike Hujistam Mi

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No

Day

3 Probably 4 ☐ Unknown

State Registrar

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Physicial   Consequence   Co	6-
Security	
St. Mary's Hospital  St. Mary'	М
Funeral Director    Second Sequentially Name   Second Sequence of December   1 may 2 mark   1 ma	
Seguentially list conditions	
10a. State   10b. County   10c. City, Town or Location   10c. City, Town or Location   10d. Inside City Lit   10	
Physician //Medical Examiner    Burial 2x/Cremation 3 Hemoval from State 4   Donation 5   Other (Specify)	mits
Physician //Medical Examiner    Burial 2x/Cremation 3 Hemoval from State 4   Donation 5   Other (Specify)	No
Physician //Medical Examiner    Burial 2x/Cremation 3 Hemoval from State 4   Donation 5   Other (Specify)	
Physician //Medical Examiner    Burial 2x/Cremation 3 Hemoval from State 4   Donation 5   Other (Specify)	
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Physician //Medical Examiner  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Betwee Onset and Death disease or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions, a large, leading to immediate and provided to enterpolate.  Due to (or as a consequence of):	
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Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deat of the cause of the	
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24a. Was an autopsy performed? 1 Yes 2 DNo 1 Yes 2 DNo 1 Yes 2 DNo 1 Yes 2 DNo 1	lable e of
performed?	
The state of Death (Check only one)  25. Was case referred to medical examiner?  Hospital: Other	
1 Himpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Hesidence 6 Other (Specify)	-
27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28d. Describe how injury occurred 28d. Describe how injury occurred	
2 Accident investigation   M   1   Yes 2   No    2 Accident   3   Suicide   5   Could not be determined   286. Place of Injury. At home, farm, street, factory, office   28f. Location (Street and Number or Rural Route Number)	
27. Manner of Death 1 Describe now injury occurred  28d. Describe now injury occurred	
1   Matural   2   Accident   3   Suicide   4   Homicide   5   Pending investigation   6   Could not be determined   5   Month, Day Year)   1   Work?   1   Yes 2   No   No   No   No   No   No   No	
29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)	
Katie Del previo, MD Do060501 September 21,20	Po
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	
Katie Del Pierro MD P.O. Box 527 Leongratown md 20650	
State 31 Date filed (Month, Day, Year) 32. Registrar's Signature	

			For State Registrar	State of	f Marylan	-	artment of rtificate o			lental Hyg	iene	9	320	343
			1. Decedent's Name (First, Middle	, Last)						2. Date of Deat Month	n Day	Year	3. Time o	f Death
	Physici /Medic		Fred Alvin Wil	liams						September			9:04	РМ
	Examin		4a. Facility Name (If not institution	give street and nur	nber)		4b. City, Town	, or Location	on of Death		4c. County			
			St. Mary's Ho	spital			I	Leona	rdtown	ı	St	. Ma	ry's	
	Funeral		5. Social Security Number	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. I	• • • • • • • • • • • • • • • • • • • •	If Under 1 Yea Months Day		ter 24 Hrs. s Min.	8. Date of Birth (Month, Day,	Year)	9. Birth	olace (State ontry)	or Foreign
- 10	Director		249-44-1967	TEM ZLIF	76	Yrs.				June 5,	1933	Sout	h Caro	lina
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	ocation						10d. Inside C	City Limits
	faryla sho	5		t. Mary's				a la a a d	csvi1	1 -				2 <b>∑</b> No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mentall Hygiene.  Department of Health and Mentall Hygiene.  Beginner of Health and Mentall Hygiene.  Beginner of Health and Health and Health and Health and Health and Indianal and Indianal Andree.	ect	10e. Street and Number	c. Hary B			10f. Zip Code		CSVII		Og. Citizen of W	hat Cou	ntry?	
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	death with the Maryland ms 23a or 28e-f show	Funeral Director	11. Marital Status	2005								- Ameri	can Indian,	
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21215-0036	72 hours after naturel', or Ite	Completed	15. Decedent	's Education t grade completed)		16a. Dece	dent's Usual Occ	cupation	nost of work	ring	16b. Kind of Bu	sin <i>e</i> ss/Ir	dustry	
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and pure	be fi	Be	17. Father's Name (First, Middle, I							e (First, Middle, M		9)		
Maryland	d Mer marke natic	٦ د	Carl E. Willi  19a. Informant's Name/Relationsh			10h Mailie				augherty  al Route Number,		Cto to 7i	- Code)	
Z Z	d 2 st th and 7 is r treur						Dockst							
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ية	ages nt of tritition		1 ☐ Burial 2 🖫 Cremation		State	emetery, crei	matory or other p	olace)		show 25	lexandri	-		
Baltimore,	it. Pertant		* 4 □ Donation 5 □ Other (Sp 21. Signariue of Funeral Service I		Met		an Cremato  Name and Ado			2009 '	rexamer i	a, VI	Iginia	_
Ba	permi Depare Impo any ir		Milaland	841	l.		Mattingle	ey-Gar	diner E	uneral Ho	ne, P.A.			
	00000		23a. Part J. Enter the disease, or	complications that c	aused the death		P.O. Box	270 I	eonard	town, MD 2	0650	-	Approxima	te
			show, or heart failure. List Immediate Cause (Final	only one cause on e	ach line.	A -							Interval Be Onset and	tween
	Physician / /Medical		disease or condition resulting in death)	a	CRUA	uer	arri	X Bis	nia				nenu	tes
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Ann. Box 68	leath certifical attending phy I for use as th		IE EENALE.											
₹ ŏ	th cer endir r use	Physician/Med	IF FEMALE: 23b. Was decedent pregnant		come of pregna		Ectopic pregnar	ncv			23d. Date		*	.,
· · ·	deal	sicie	in the past 12 months?		ant at time of de		Other (specify)				Mor	ith	Day	Year
P.O.	that the ed by th detache	hy	9 Unknown 7 PT							1				
2,0	as und	by	Part II. Other significant condition	ns contributing to de	eath but not resu	ulting in the u	nderlying cause	given in Pa	ırt I.		acco use contri			
	w requires been sign should be	ted					_			1 L Y 6	s 2 No	3 <u>  </u> F10	Dably 4	Onknown
Recor	las b	Completed								24a. Was a autops	v - D	rior to co	opsy findings impletion of a	available cause of
(m)	: The law cate has l	Cor								perform	No 1	eath? □Y <i>e</i> s	2 🗆 No	
	Physicien: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Lia anitali		1	_		ace of Deat	h (Check only on	9)			
2º	Physical this call dir	2	1 ☐ Yes 2 ☐ No 27. Manny of Death			ER/Outpatier	IL SLI DOA		Nursing Ho	ome 5 Reside			fy)	
	ing I	lon	1 Matural 5 □ Pendin		of Injury th, Day Year)	28b. Time of Injury	W	njuryat Vork? □Yes 2	□ No	28d. Describe ho	w injury occurre	∌d		
3 is	Attending r death. sctor: After y the fune	Cat	2 Accident investig	ot be	of Injuny - At ho	ma farm etr	eet, factory, office			28f. Location (St.	reet and Numbe	er or Bur	al Route Nun	nher
Ω̈́≥	after Direct in by	Certification;	4 ☐ Homicide determi	ned buildii	ng, etc. (Specify	/)	eet, ractory, onic	20		City or Town	, State)	# Of 1101.	21 1 10016 14011	iber,
	Hospitel		29a. Certifier Certifyin	g Physicien: To the	best of my know	wledge, deat	h occurred at the	time, date	and place.	and due to the ca	iuse(s) and mai	nner as s	stated.	
	e Ho 24 h e Fur letely	Medical	(Check only 2 Medicel I one)	Exeminer: On the ba	asis of examinat ner stated.	tion and/or in	vestigation, in m	y opinion,	death occur	red at the time, da	ate and place, a	nd due t	o the cause(	s)
	To the Hospitel or Attending Physicien: Thin, 24 hours after deals after deals To the Funerel Director: After this certification the funerel director; completely filled in by the funeral director;	Me	29b. Signature and title of certifier	1			29c. Lice	ense numb	9r	2:	9d. Date signed	(Month,	Day, Year)	
			1 Denta	- 19	n	din.	73	982	Ĵ.		9/-	4/2	9	
. 2 .	8		30. Name and dress of person	who completed caus		23a) (Type,	Print)				1-	-		
5 m	_		JAMES DA	nActeu	27 f		ax 524	1 2	con	ard Tou	er, m	δ.	>06 5	50
	Sta		31. Date filed (Month, Day, Year)	A.C	egistrar's Signal		2.0				/			
-	Registr	ar	35 L % - 701	19 anous	v p.	4000								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1853 PM M ERIC WILSON 2009 20 Sept /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE UMMC If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 10-24-1960 6. Sex 1 🕅 M 2 🗆 F 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Baltimore, MD 48 Director 216 78 2239 Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene. 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Evan ther that be notified at Y☐Yes 2☐No Director MD Baltimore Baltimore City 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 418 Watty Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Specify: Black 1 Tyes 2 No Specify ò 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Private 12th Laborer permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important; If item 27 is marked oth any linjury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jessie Wilson Minnie Higgs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2713 Spelman Rd Baltimore Md, 21225 Christine M. Joseph 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 Cremation 3 Removal from State Branches Cemetery 9-29-09 Winterville, NC 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility Briscoe-Tonic FuneralHome 2294 Old Washington Rd Waldorr Md, 20601 23a. Prrt 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death (MAC) Immediate Cause (Final disease or condition resulting in death) **Physician** Disseminated mycobacter's arive complex infection /Medical Due to (or as a consequence of): Examiner HIV /4165 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) Pregnant at time of death the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2**X** No 1 □Yes 2 XNo 1 □ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) Hospital or Attending Pl
 4 hours after death.
 Funeral Director: After t 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

State Registrar

DHMH 17 Rev 1/2001

29a, Certifier

(Check only one)

29b. Signature and title of certifier

ANDREA HUANG

31. Date filed (Month, Day, Year)

Medical

Baltimore, Maryland 21215-0036

executed

The law requires that the death certificate be

P.O.

Records,

of Vital

Division

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11 S. ENTAN ST. #919 BALTIMORE 32. Begistrar's Signature

1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

1467687657

29d. Date signed (Month, Day, Year)

Sept 20, 2009

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Washington 1200 PM 09 Ihomas 900ء 16 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Univ. of Maryland Medical System Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 09-09-1958 Birthplace (State or Foreign Country) 6. Sex **Funeral** 1.2 M 2□ F Days Hours Min. 5 Director 218-78-3415 Maryland Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. em 27 is marked other than "natural", or items 23e or 28e-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Caroline 1 ☐ Yes 2 ☐ No Funeral Director Md. Federalsburg 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 21632 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 □Yes 2XNo Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electrician 12 Allen Family Foods 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Baltimore, Maryland Be William ပ Joyce Delma item 27 is marke other traumatic Dennis Washington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 208 Tilshman AVC, Federalsburg, Md, 2/632.

20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or Town, State Gen Washington, Pages 1 20a. Method of Disposition permit. Pages 1 Department of F Important: If ite any Injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 09-26-09 Federalsburg, md. 5 ☐ Other (Specify) Federal Hill Cem. 21. Signature of Funeral Se 22. Name and Address of Facility Bennie Smith Funeral Home rvice Lisensee Hurlock Main Street 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Anoxic Brain Injury /Medical Due to (or as a consequence of **Examiner** Status Epilepticus

Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒No 24a. Was an 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1XYes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation To the Hospital or Attenct within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 🛮 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 1871728741 09/10/2009 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Greene St., Baltimore, IRK Samuel Pan 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 21, 2009 **Physician** 4:20 PM Janet Cathryn Wolf /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard 4102 Red Bandana Way Ellicott City If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. Aug 17 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Ohio fg31 1 □ M 2X F 344-24-8131 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10b. County 10a State 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Expression must be notified at 1 ☐ Yes 2 XNo Director Columbia MD Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21044 10714 Shady Summer Drive Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify Specify: White þ 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 7 is marked other traumatic event, in 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and Mental Mary Ellen Curry Cyril Stephen Lauer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other tra once. 4102 Red Bandana Way Ellicott City, MD 21042 Cathryn Ann Munn/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Final Journey Crematory 09/23/09 Woodbine, MD 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licen Going Home Cremation Service P.O. Box 784 MD 21029 Beverly L. Heckrotte, P.A. Clarksville, MO1251 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** years 0 hera /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Day 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 Yes 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □Yes 2 ☑ No 2 □No 1 ☐ Yes this certific al director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be daughter's Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA NOME ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: d in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) the Funeral Directory filled in by determined 4 Homicide 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 1 within 2.
To the I complet 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 541+ 9105, 13 alto md 21204 23-

State Registrar

345h 31. Date filed (Month, Day, Year) SEP 2 4 2009 32. Begistrar's Signature

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**Funeral** 

Director

28a-f show

items 23a or

ŏ

"natural"

**Physician** 

/Medical

Examiner

physician

Medical Examiner must be notified at

the Maryland

or Attending Physician: The law requires that the death certificate be executed

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** September 29, 4:24 a.m. Alexander Williams 2009 Bernard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Mary's California 24169 N. Patuxent Beach Road If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Sex 1 M 2 □ F Months Days Hours 86 223-28-2070 03/15/1923 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 ☐Yes 2 X No Director Maryland St. Mary's California 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 24169 N. Patuxent Beach Road 20619 United States 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 XYes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No 1 ☐ Yes 2 🛣 No þ Specify: 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Salesman Automotive 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Walter Ernest Williams Mary Coffman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Simmons/Daughter 10745 Kasota Road, Chestertown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Brinsfield-Echols Crel0/01/2009 | Charlotte Hall, MD 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service Licensee 5 Kyle S. Simons MÓ1206 22955 Hollywood Road, Leonardtown, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final a. Prostate Cancer disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Jause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 X No 1 ☐ Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🕅 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 1 XNatural 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 ☐Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 🗌 Homicide 29a. Certifier 1 Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 100019052

To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completely filled in by the fun

DHMH 17 Rev 1/2001

After

State Registrar

31. Date filed (Month, Day,

Bennett,

23263 By The Mill Road, California, MD M.D.32 Registrar's Signatur

Januel 11/ 30. Nam and address of person who completed cause of death (Item 23a) (Type, Print) 1. Decedent's Name (First, Middle, Last)

**Physician** 

/Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Union Hospital Ceci1 Elkton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) OCT 9, 1935 5. Social Security Number 6. Sex 1 M 2 □ F Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Months 73 Pennsylvania 162-28-0907 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show injury or other traumatic event, the Phological Examiner must be notified at 1 ☐ Yes 2 X No Completed by Funeral Director Maryland Ceci1 E1kton 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or items 23a 367 Fletchwood Road, Apartment A-21 21921 Unit**ed** States 12. Was Decedent Ever in U.S. Armed Forces? 1953—1 Myes 2 No If Yes, Give 1955 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, it a Medical Examinat 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 □Yes 2 💢 No Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Transportation 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be George Thomas Young Margaret Regent ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrea Lappas Young/Wife 367 Fletchwood Road, Apartment A-21, Elkton, MD 21921 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 2. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State R. A. Ferris & Co., Inc. 2009 West Chester, PA 4 ☐ Donation 5 ☐ Other (Specify) Hicks Home for Funerals, P.A.
103 W. Stockton Street, Elkton, MD 21. Signature of Funeral Service Licensee 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner morar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine ein Due to (or as a consequence of) attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred spital or Attending Pinous after death.
neral Director: After ty filled in by the funers 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier September 30, 2009 D0059223 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Melchor E. Madarang, M.D. 215 North Street, Suite C, Elkton, MD 32. P gistrar's Signature 31. Date filed (Month, Day, Year) State Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

William George Young

2. Date of Death Month

September 30, 2009

Year

1308 P M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death September 19, 2009 Albert Clarence Zimmerman 5:50 A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hal Charlotte Hall Veterans Home St. Mary's 8. Date of Birth (Month, Day, Year) June 17, 1921 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Social Security Number Pennsylvania 1 □ M 2 □ F Days Months Hours Min. 169-18-4324 88 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐Yes 2√ No Maryland St. Mary's Charlotte Hall 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 29449 Charlotte Hall Road 20622 12. Was Decedent Ever in U.S. Ariped Forces? 1 Pyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 ☐ Never Married 2 ☐ Married 1 □ Yes 2 No White Specify. 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2<sup>College (1-4or 5+)</sup> Elementary/Secondary (0-12) Mailman U.S. Postal Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Albert Zimmerman Anna Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary Ann Zimmerman/Daughter 4302 Taunton Drive, Beltsville, MD 20705 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State September Brinsfield-Echols Crem. 4 ☐ Donation 5 ☐ Other (Specify) 21, 2009 Charlotte Hall, MD 21. Sign sture of Funeral Sorvice Licensee 22. Name and Address of Facility Brinsfield-Echols F.H., P.A., M00817 30195 Three Notch Rd., Charlotte Hall, MD 20622 Approximate Interval Between Inset and Death Raft 1. Enter the disease, or corr shock, or heart failure. List only or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Immediate Cause (Final disease or condition resulting in death) quence of): Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISSTEAL 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural
2 Accident

**Physician** /Medical Examiner requires that the death certificate be executed

**Physician** 

/Medical

**Examiner** 

**Funeral** 

Director

show

Director

Funeral

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Completed

Be

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7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the Position Examination as to rediffice at

within 72

12 should be filed within 7 th and Mental Hygiene. 7 is marked other than "n

permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any Injury or other traumatic ev

Baltimore, Maryland 21215-0036

Box 68760,

P.0.

Records,

of Vital

Division

Examiner burial-transit

and attending physician for use as the burial Physician/Medical signed by the a þ Completed been cate has t certificate To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. Be Certification: To

28a. Date of Injury (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Pertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifier

6 ☐ Could not be

determined

29c. License number 46046 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Amir M. Alikhani, Potomac, MD

31. Date filed (Month, Day, Year)

3 ☐ Suicide

29a. Certifier

ical

4 Homicide

(Check only one)

32. Relistrar's Signature

DHMH 17 Rev 1/2001

State Registrar

			1 - State Registrar	Otato of Mi	ar yraria /	-	tificate of	Death	wientai i iy	Reg. No		32000
	Physic /Medi		1. Decedent's Name (First, Middle, La	st)	alex	(au	def		2. Date of De Month	eath Da		3. Time of Death
and the same	Exami		Baltim were lifnot institution, giv	e street and number)	Pel Can	e	4b. City, Town,	or Location of Deat	h	40	C. County of Death	'/A
	Funeral Director		5. Social Security Number 6. S		e (In yrs. last bi	rthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Da	ay, Year,	9. Birthp Cour	place (State or Foreign ntry) VA
	yland now		10a. State 10b. County		10c. City, Tow	n or Loc	ation				1	0d. Inside City Limits
	ne Mar Ba-fsl	Director	MD Balti	more	Pik	ėsv	ille					1 ∐Yes a∏No
	th with the 23a or 2	ral Dire	10e. Street and Number 7219 Park He	ights Av	enue		10f. Zip Code 2120	8		10g. C	itizen of What Cour	ntry?
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, Its Marical Exercines must be notified at	by Funeral	11. Marital Status  1. Wester Married  3 Widowed 4 Divorced	12. Was Decedent I Armed Forces? 1  Yes 2  N If Yes, Give Year or Dates:		1 -	/as Decedent of Yes, specify Cub □Yes 🏋 🖫 No	Hispanic Origin? (S ban, Mexican, Puerl Specify:	pecify Yes or No to Rican, etc.)	)-	14. Race - Americ Black, White, of Specify:	
Baltimore, Maryland 21215-0036	nin 72 ho in "natur Medicel	Completed	15. Decedent's Ed (Specify only highest gra	de completed)		. Decede (Give k life. D	ent's Usual Occu ind of work done O NOT use retire	pation during most of wor	rking	16b. k	Kind of Business/Ind	dustry
212	filed with Hygiene other tha ent, tre	Com	Elementary/Secondary (0-12)	College (1-4or 5	+) L	abo				Ве	ethlehem	Steel
and	d be fill antal H ed oth even	Be	17. Father's Name (First, Middle, Last)					18. Mother's Nar			,	
ary	2 should be and Mental is marked c	2	Everett  19a. Informant's Name/Relationship (		exande 191	r o. Mailing	Address (Street	Lula t and Number or Ru	aCh	er. City	.ham or Town, State, Zin	<sup>Code)</sup> 21208
Š	and 2 ealth a n 27 is ier tra		Bernice Ford-	friend		721	9 Park	Heights	a Ave.	Pik	esville	, MD
ore	Pages 1 nent of H int: If iter iry or oth		20a. Method of Disposition  XXBurial 2 □ Cremation 3 □	Removal from State			ition <i>(Name</i> of atory or other pla		Date		ocation - City or To	,
altin	permit. Pages Department of Important: If ii any injury or o		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen		Garr	22.	n Fores	ess of Facility MA	RCH FU	NER	ings Mi AL HOME	-EAST
0	8 9 <b>5 8 9</b>		1 Dlady	War	-	1	TOT E.	North A	Avenue	Bal	timore,	MD 2120
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a. Carci	the death. Do e.  21 UMCk a consequence	9		ng, such as cardiad	c or respiratory a	rrest,	24	Approximate Interval Between Onset; and Death
6876U,	incare be executed g physician and s the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	a consequence							
	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 ☐ Live birth 1 ☐ Pregnant at 9 ☐ Unknown	2 Fetal death		Ectopic pregnand Other (specify)	су			23d. Date of delive Month	ery Day Year
ecords, 1	n signed	by	Part II. Other significant conditions co	ontributing to death bu	t not resulting in	the und	lerlying cause giv	en in Part I.			use contribute to th ☐ No 3 ☐ Prob	/
The law re	cate has bee	Completed							24a. Was autop perfo 1 🗆 Yes		prior to cor death?	psy findings available ppletion of cause of 2 □No
VITAL Sician:	certifi	Be o	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital:			3 DOA Oth	26. Place of Dea				
5	ter this	n: To	27. Manper of Death	28a. Date of Injur (Month, Day,		Time of	3 DOA 28c. Inju	4 LI Nursing H	ome 5 ☐ Resident 28d. Describe I		6 ☐ Other (Specify ry occurred	y)
VISION	death. ctor: Aft y the fun	Certification: To	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	(Month, Day,		njury	M 1□	k?  Yes 2□No				1.C. de Manda
Oly offers	urs after eral Dire		4 Homicide determined	building, etc.	(Specify)				City or Tov	vn, State		
Host	n 24 ho ne Fune oletely f	ledical	29a. Certifier  (Check only one)  1 Certifying Phy 2 Medical Exam	vsician: To the best o iner: On the basis of and manner stat	examination an	e, death o d/or inve	occurred at the ti estigation, in my o	me, date and place opinion, death occu	e, and due to the rred at the time,	cause(s date an	s) and manner as si d place, and due to	tated. the cause(s)
Tot	To th	Me	29b. Signature and title of certifier		M. D		29c. Licens		(0)	29d. Da	te signed (Month, I	Day, Year)
			30. Name and address of person who c	43	ath (Item 23a)	(Type, Pr	int)	359(0H RoDFimore,	h.	1 1	5 0/	<b></b>
	Stat Registra		31. Date filed (Month, Day, Year)	32 Registral	r's Signature	South	ward, 13	altibury	rnasyla	Reef	2-148	5

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5, 10:00 AM 2009 October Helen Theresa Abbruscato /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Bel Air 1011 Leeswood Road 8. Date of Birth (Month, Day, Year)
Aug. 25, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 X F New York 90 1919 Director 103-05-9039 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Director Bel Air Harford Maryland, 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21014 USA 1011 Leeswood Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. けのしる イトトンソスaltimore, Maryland 21215-0036 1 Never Married 2 Married 1 ☐ Yes 2 🔯 No Specify à New York 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) n and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Josephine Marie Mariano Peter (nmn) Brienza Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 is any Injury or other trains 410 Cedar Springs Rd., Bel Air, MD 21015 Francine R. Leach / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 2 □G¶emation 3 □Remova 1 K Bui 4 🗆 D Other (Specify 10-08-09 Bel Air, Maryland tion Bel Air Memorial Gdn. McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21. Sign Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardial or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death 23a Part1. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Le to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to introduce cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Examiner the Hospital or Attending PhysIclan: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl for use as t 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 | No 3 | Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a, Was an certificate has be irector, page 2 s autopsy performed? Yes 2XNo 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🗙 No Certification: To this funeral 28d. Describe how injury occurred 27. Manner of Death 1. Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 ☐ Suicide 4 Homicide certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29d. Date signed Month, Day, Year) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Dimonson 32. Registrar's Signature 31. Date filed (Month, Day, Year)

OCT 09 State Linera Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Physician 7:20 A DORIS DUHAIME ATCHISON OCTOBER 6, 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner UPPER CHESAPEAKE MEDICAL CENTER BEL AIR HARFORD If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours 1 M 2 K Director 22, 1936 Canada 454-80-0332 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ortant; If item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the <u>Medical Examiner must be notified at</u> 1 ☐ Yes 2 ☐ No Director Maryland Harford Abingdon 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 309 Tiree Court Unit 404 21009 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S Armed Forces? 11. Maritai Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: ð 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than ' Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrative Assistant Parks & Recreation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gertrude Marie Laroche <u>Arthur Alexander Duhaime</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 Is any Injury or other trau 305 Farm Lane, Aberdeen, Maryland 21001 Kevin Atchison Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 120 rial 2 Cremation Other (Spe city) Arlington Nat'l Cem. 10-28-09 Arlington, Virginia nation 21. Sig McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 eart1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Kespirator **Physician** /Medical Due to (or a a consequence of): **Examiner** WONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) Chison Dyrig MSUUSUUM Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Day Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown ils certificate has been signed by director, page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. þ 3 Probably 2 No 4 □Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? res 2 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 2 No Hospital: 2 MER/Outpatient 3 □ DOA 1 Tyes 1 Inpatient Certification: To this the funeral 27. Manual of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? (Month, Day Year) 5 ☐ Pending investigation 1 Matural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide Wertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and the of certifier

State Registrar 30 Name and add

J.D 500 Eadorlan Yomil 31. Date filed (Month, Day, Year) 2009

ress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Chesapeake Drive

17	17	2	1	
J	blone		V	٩.,

			State of Maryland / Department of Health and M  1- State Registrar Certificate of Death		iene       9	32350
			Decedent's Name (First, Middle, Last)	2. Date of Deat	h	3. Time of Death
	Physicia		Ronald D. Abbit	Month 10	05 2009	1145 <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death		4c. County of Dea	th
	- Agiiiii	,	Heartland Nursing and Rehab Center Adelphi		Prince G	eorge's
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day,	Year) 9. Bir	thplace (State or Foreign ountry)
ш	Director		218-78-9077 1\(\overline{\text{Q}}\) M 2 \(\overline{\text{F}}\) 47 Yrs. Months Days Hours Min.	03/09/		NC
	pu s	-	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	daryle sho	ō				1 X Yes 2 No
	28a-1	ect	MD Prince George's Hyattsville  10e. Street and Number 10f. Zip Code	1	Og. Citizen of What C	ountry?
	with Se or	Funerai Director		,	JSA	
	death	era	11 Marital Status 12 Was Decedent Ever in U.S. 13 Was Decedent of Hispanic Origin? (Spe	cify Yes or No-	14. Race - Am	
9	after or Ite		Armed Forces? If Yes, specify Cuban, Mexican, Puerto I  1 □ Never Married 2 □ Married I 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	rican, etc.)	Black, Whi	te, etc.
03	72 hours after death with the Maryland naturel; or Items 23a or 28a-f show Iteal Examiner must be notified at	t by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give 1984 1☐ Yes 2 ☒ No Specify:		Specify: B1	ack
2	72 h 'natu	etec	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working)		16b. Kind of Business	/Industry
121	be filed within 72 hours after death with the Marylan ital Hygiene. od other then "naturel", or Items 23s or 28s-1 show event, tre Medical Examiner must be milling at	Completed	Elementary/Secondary (0-12)  College (1-4or 5+)  F. L. Office Manager	-	Padadas Mo	m Comotory
7	filled v Hygie other i		5+ Office Manager  17. Father's Name (First, Middle, Last) 18. Mother's Name			m. Cemetery
an	ould be i Mental larked o	o Be	Royal J. Abbit Sr. Virgini			
Maryland 21215-0036	2 should be and Menta Is marked eumatic ev	유	19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailing Address ( <i>Street and Number or Rura</i>			Zip Code)
	127 E B		Virginia W. Abbit/mother 1320 Jefferson St. Hy	attsvil:	le MD 2078	2
Je,	is 1 and 2 of Health item 27 other tre		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery crematory or other place)		20c. Location - City o	Town, State
altimore,	Page ient o nt: If		1⊠ Burial 2 ☐ Cremation 3 ☐ Removal from State  1 ☐ Cremation 3 ☐ Removal from State  1 ☐ Cremation 5 ☐ Other (Specify)  1 ☐ Cremation 5 ☐ Other (Specify)	15 2/2009	Clinton l	Maryland
alti	permit. Pages 1 Department of H Importent: If ite any injury or ot once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility Man		Funeral H	lome
<u>m</u>	82589	. 14	4217 9th St NW Wash	nington	DC 20011	
в			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac c shock, or heart failure. List only one cause on each line.	r respiratory arr	est,	Approximate Interval Between Onset and Death
	Physician	i p	Immediate Cause (Final disease or condition resulting in death)  a Cardiorespiratory Arrest resulting in death)			
	/Medical Examiner		Due to (or as a consequence of):			
	. F	e	Sequentially list conditions, if any, leading to immediate b. Encephalopathy  Due to (or as a consequence of):			
	uted 3 ansit	Examine	Cause Disease or injury that initiated events c. Large Cell Brain Lymphoma			
Ć	exec an an		resulting in death) Last Due to (or as a consequence of):			
68760,	icate be executed physician and s the burial-transit	edicai	Acquired Immunodeficiency Syndrom	e		
_		Med	IF FEMALE:		1	1
Вох	death certifii e attending p id for use as	ian/	23b. Was decedent pregnant in the past 13 months?  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 3 Ectopic pregnancy		23d. Date of de Month	alivery Day Year
0	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 5 ☐ Other (specify)			
۵.	that the de led by the a		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute	to the cause of death?
ds,	es be	d by	Cereborvascular Accident	1 □ Y	es 2XINo 3∐F	Probably 4 Unknown
COL	w requir been si should	lete	Bacteremia/Sepsis	24a. Was a	an 24b. Were a	utopsy findings available
Vital Records,	The law ate has b page 2 st	Completed		autops	med? death?	completion of cause of s 2□ No
tal	en: Th rtificate tor, pag	ပိ	Diabetes Mellitus Type II  25. Was case referred to medical 26. Place of Death	1 Yes		5 2 110
>	Physicien: this certific ral director,	0.0	examiner?		ence 6 Other (Sp	ecify)
οι		ın: T	(Month Co., Vand Later)	28d. Describe h	ow injury occurred	
10	at at	atic	2 Accident investigation M 1 Yes 2 No			
Division	or Atten after deat Director; in by the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow	treet and Number or I n, State)	Rural Route Number,
Ω	urs al arel D		Con Continue of Continue Physicist To the head of Continue Physicist To the Physicis To the Physicist To the Physicist To the Physicist To the	and di- 4-	augusta) and and	an atatad
	To the Hospitel or Atte within 24 hours after de To the Funerel Direct completely filled in by th	edicai	29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, of check only one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.			
	To the within 2 To the complet	Med	29b. Signature and title of certifier 29c. License number	2	29d. Date signed (Mor	nth, Day, Year)
	->-0		Dwy Toning MD 47867		10/6/2009	
	h.1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)		, _,,	
	9 V		Oney Zuniga 4701 Randolph Rd. #216 Rockville MD	20852		
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature			
	Registi	ar	OCT 0 9 2009 Busta B. Bally			

P.O. Box 68760 Division of Vital Records.

		For State	State o	of Marylar		artment of F		d Mental Hy		7 A A A	0.000
	-	Registrar  1. Decedent's Name (First, Middle,	Last)			incate or i	Death	2. Date of D	Reg. No.	2.009	3. Time of Death
Physic /Medi		SIDNEY	W		ALBER	RT				7. EVER	27:26AM
Exami		4a. Facility Name (If not institution, Saint Joseph	give street and nu 1 Medic	ımber) :al Cer	iter	4b. City, Town, or		eath √50∏	4c. C	County of Death Balt	imore
Funeral Director		5. Social Security Number 220-24-8461	. Sex 1 <b>X</b> M 2 □ F	7. Age (In yrs. 80	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours A	8. Date of B (Month, D 08/28)	rth (1929)	9. Birthp Coun	lace (State or Foreign try) MD
<b>,</b>		Usual Residence of Decedent		10- 0	. T					14	0d, Inside City Limits
laryla Fshov	o	MD BALT	IMODE	100. 01	ty, Town or Lo	TOWSON				'	1 ☐ Yes 2 🛣 No
the N 28a-1	rect	10e. Street and Number	HIOKE			10W3UN			10g. Citize	en of What Coun	try?
h with 23a or	Funeral Director	302 EAST JOPPA	ROAD, #	1410		2128	6		U:	SA	
r deat	ner	11. Marital Status	12. Was Dec	edent Ever in U		Was Decedent of H If Yes, specify Cuba	lispanic Origin an, Mexican, P	? (Specify Yes or Nuerto Rican, etc.)	0- 14	4. Race - Americ Black, White, e	
be filed within 72 hours after death with the Maryland tall Hygiene.  Idea ther than "natural", or items 23a or 28a-f show event, if a Medical Evarring rust be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🛣 Widowed 4 ☐ Divorced	1 Yes If Yes, Gi Year or D			1 □Yes 2 <b>火</b> □No	Specify:		5	Specify: WHI	
2 hour		15. Decedent's	Education		16a. Dece	dent's Usual Occup	ation		16b. Kind	d of Business/Inc	dustry
thin 7:	Completed	(Specify only highest Elementary/Secondary (0-12)		1-4or 5+)	WORK	kind of work done of PENS use office	guring most of ENSATIO	working N			
led wi Hygien her th		47 Fall of Name (First Adjudge La				ISSIONER				E OF MAR	RYLAND
ges 1 and 2 should be filed within 72 hours after death with the Marylan ges 1 and 2 should be filed within 72 hours after death with the Marylan to f Health and Mental Hydene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Everniner must be notified at	To Be	17. Father's Name (First, Middle, La MORRIS	St)	AL	BERT			Name <i>(First, Middl</i> i PHIE	e, maideri S	TEITLE	ER .
should land Men s marke s marke	-	19a. Informant's Name/Relationship	(Type. Print)			ng Address (Street		r Rural Route Num	ber, City or		
T and 2 Health a em 27 is		RACHEL BRUBAKI	ER / DA	UGHTER			L ROAD	, BALTIMO			
Pages 1 nent of H int: If iter		20a. Method of Disposition 1	☐ Removal from	State 0	HEI TERVER	sition (Name of place	e)	Date		ation - City or To	
Title a		4 ☐ Donation 5 ☐ Other (Spe 21. Signature of Funeral Service Lice	1.1	B	ETH ISE	RAEL.	110,	/08/2009   SOL LEVI	NSON 5	ALTIMORE	TNC
permit. Departing Importa		Lection 1	Juger					WN ROAD,			
		23a. Part 1. Enter the disease, or co shock, or heart failure. List or	mplica one that only one ause on o	caused the deat each line.	h. Do not ent	er the mode of dyir	ng, such as car	diac or respiratory	arrest,		Approximate Interval Between Onset and Death
Physicían /Medical		Immediate Cause (Final disease or condition resulting in death)	a	UMONIA							SHOOT AND DOG!
Examiner				(or as a conseq GESTIV		RT FAIL	URE				
70 ==	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to	(or as a conseq	uence al).						
ecuter and transi	Examiner	if any, leading to infine late cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	U			L DISEA	SE				
cate be executed physician and the burial-transit		and a second second	Due to	(or as a conseq	uence or):						
phys the	edical		d						Т.		
The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 ☐ Live	itcome of pregnation 2 ☐ Feta grant at time of a grown	al death 3 [	Ectopic pregnanc Other (specify)	у		23	3d. Date of delive Month	ery Day Year
res that signed b	by Pr	Part II. Other significant conditions	s contributing to d	leath but not res	ulting in the ur	nderlying cause give	en in Part I.	23e. Did	tobacco us	e contribute to the	ne cause of death?
w require	ed b	RENAL CELL	CARCING	OMA				1	Yes 2	No 3□ Prob	ably 4 ☐ Unknown
sician: The law r certificate has be irector, page 2 sh	Completed	CORONARY AR	TERY D	ISEASE				— 24a. Wa auto peri 1 □ Yes	s an opsy ormed? 2 X No	prior to con	psy findings available mpletion of cause of 2 No
Attending Physician: or death. ector: After this certific. by the funeral director, is	Be (	25. Was case referred to medical examiner?	Hamital			Ott		Death (Check only			
Phys r this ral dir	<u>P.</u>	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1X	<u> </u>	ER/Outpatier 28b. Time of		4 🗀 Nursii	ng Home 5 ☐ Res 28d. Describe			y)
nding tth. : Afte e fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigat	(Mon	nth, Day, Year)	Injury	Work	Yes 2 □ No	Zou. Describe	Tiow injury	occarred	
or Atter after dea Director in by th	Certification:	3 ☐ Suicide 6 ☐ Could not determine	be 28e. Place build	e of Injury - At he ling, etc. (Special	ome, farm, str fy)	eet, factory, office		28f. Location City or To	(Street and wn, State)	Number or Rura	l Route Number,
Hospital 4 hours Funeral tely filled	Medical Ce		aminer: On the b					lace, and due to th occurred at the time			
To the within 2 To the comple	Me	29b. Signature and title of certifier	1-0	4.4	7	29c. License	e number		29d. Date	signed (Month,	Day, Year)
		Time	1 to	Co.M.	P	D24	034		1	0/7/0	9
7		30. Name and address of person wh	o completed caus			,	TOUCOS	I MABALA	With the	1 2004	
Sta	ite	31. Date filed (Month, Day, Year)	32.	7501 egistrar's Signa			LOWOUI	4. MARYLE	114L/ III	1204	
Registr	ar	OCT 09	2009 /	news .	B. A.	ald					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2009 14 HM **Physician** C. 0 Ronald Barnett /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner seda le Social Security Number timor rafe Birthplace (State or Foreign Country) If Under 24 Hrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Months **№**М 2 | F 7,1947 Pennsylvania Aug. Director 177-36-1639 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2\times\text{No ns 23a or 28a-f sh must be notified Maryland Baltimore Parkville Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21236 U.S.A. 45 Bayberry Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 and 2 should be filed within 72 hours after of Health and Mental Hygiene. tem 27 Is marked other than "natural", or itei 1 Never Married 2 Married 1 ☐ Yes 🛣 No Specify: Specify: ģ White 3 Widowed 4 Divorced altimore, Maryland 21215-003 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) injury or other traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Retail Manager Home Improvement Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anna Jane Mlinek Charles A. Barnett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 Is any injury or other trainonce. Justin L. Ferguson (Personal Rep.) 45 Bayberry Road, Parkville, Maryland 21236 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Pages 1 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Oct.12,2009 Rossiter, Pennsylvania 4 □ Donation 5 □ Other (Specify) Pearce Cemetery 22. Name and Address of Eacility
Bruzdzinski Funeral Home, P.A. 21. Signature of Foreral Sec ce Licensee 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part1. Enjoy the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immedia Cause (Final **Physician** a. Hemodynamic Due to (or as a consequence of): dise or condition resulting in death) /Medical **Examiner** Congulopathy Consumption ( Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner sophagogastric Junction To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Directors: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit carcinoma of the Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 nknown Esophagogastrectomy 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an explotation autopsy performed? Yes 2. No 2 🗌 No 1 Yes 25. Was case referred to medical 26. Place of Death Check onl one Be exammer? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3∏ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated.

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Drive Baltimore MD.

29d. Date signed (Month, Day, Year)

David Clifford Bel		- For State	tate of M	laryland		tment of ificate of	Health a Death	nd Men	tal Hyg		j. No.	201	19 3235	
Physicia Medical Examin	n/	Registrar 1. Decedent's Name (First, Midd David Clifford		Sr.						Date of Death Month October 5,	Day 2009	Year	3. Time of Death 1330 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 2250 Monocacy Road Essex									4c. County of Death Baltimore County			
Funeral Director		5. Social Security Number 213–42–1189	6. Sex		ge (In yrs. las			ear If Unde	N. A.G.	8. Date of Birth		Cou	hplace (State or Foreign untry) ryland	
w any		Usual Residence of Decedent  10a. State 10b. County				Town or Locat				0.7027			10d. Inside City Limits  1 Yes 2 X No	
iryland ta-f sho	g	Maryland Balti 10e. Street and Number	more		Esse	X	10f. Zip Cod	е		10	g. Citizen o	of What Cour		
the Ma Sa or 28	Director	2250 Monocacy	Road				2122	1			U.S.			
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status  1 Never Married 2		Was Deceden Armed Forces Yes 2			as Decedent of es, specify Cu	ban, Mexicar	n, Puerto Ri		,	White, etc.	can Indian, Black,	
rs after ural", o	<u>a</u>	3 Widowed 4 X D  15. Decedent's Education (Sp	ivorced If Yes, or Da	tes:	mpleted)	1 16a. Deceder	Yes 2 X	pation (Give	kind of wor	rk done		of Business/		
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatite event, the M dical Ex. miner must be notified at once.	Completed	Elementary/Secondary (0-12		college (1-4 or	' '	during n	nost of working Preside	life. DO NOT	Fuse retired	<b>d)</b>	   Whol	esale	Lumber	
5-0036 iled within 7. Hygiene. I other than		17. Father's Name (First, Middl	e, Last)							irst, Middle, N				
2121 2121 Muld be fi marked c event,	o Be	Lee Golt Bell  19a. Informant's Name/Relation	nship (Type, F	Print )		19b. Mailin	g Address (S	Vircet and Nu	<b>ĭinia</b> mber or Ru	Dare C	1 $iffo$	rd r Town, State	e, Zip Code)	
MD 2 d 2 shor lth and ] n 27 is a	_	Elizabeth A. E			-	1514				cortes,			1 98221 Town, State	
Ore, es l and of Heal If iten		20a. Method of Disposition  1 Burial 2 X Cremati	on 3 Re	emoval from S	State C	rematory or o				Date		·		
altimore, rmit. Pages I an epartment of Hea portant: If iter jury or other tr		4 Donation 5 Other 21. Signature of Fun ral S			Bay	yview (	Cremato Name and Add	ry , Inc ress of Eacil	10/0	08/2009	Bal <u>t</u>	imore.	Maryland	
Ba perm Dep; Imp	0.7	1407 Old Eastern Avenue, Essex, Maryland 2122											land 21221 Approximate Interval	
Physician /Medical	<u>C</u> .	failure. List only one caus	se on each lin	e.				ing, such as	cardiac or i	respiratory arr	est, snock,	or neart	Between Onset and Death	
xaminer	_ •	Immediate Cause (Final diseas or condition resulting in death)		o (or as a con		ascular Di	sease							
		Sequentially list conditions, if any, leading to immediate	b	o (or as a con	sequence of	f):								
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated	c	o (or as a cor										
Ind and Indian	I Exa	events resulting in death) Las	t Due t	O (OI as a coi	isequence of									
be executed vician and unial - transi	dical	UNPENDED	AM	IENDED							120 - 5			
Sox 68760 death certificate be attending physi	In/Me	IF FEMALE: 23b. Was decedent pregnant in past 12 months?		c. If yes, outo			etal death	3 Ecto	pic pregnan	ісу		ate of delive onth	ry Day <b>Y</b> ear	
Box 6876 e death certificate the attending phy ed for use as the t	Physician/M		Jnknown 9	Pregnant Unknown	at time of de	eath 5 (	ther (Specify)							
<b>—</b> • <del>—</del> • • • • • • • • • • • • • • • • • • •		Part II. Other significant con				esulting in the	underlying ca	use given in	Part I.				o the cause of death?	
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	ed by									1 Ye			obably 4 Unknown autopsy findings available	
cord law req has bee	Completed									auto perfo	psy orm <u>ed</u> ?	prior to death?	completion of cause of	
		25. Was case referred to med	ical				26.	Place of Dea	th (Check o		2No	1 🗸 `	Yes 2 No	
Vita   ysiciar ysiciar this cer	o Be	examiner? 1 ✓ Yes 2 No	Hospi	tal: 1 Inpa	atient 2	ER/Outpatie				Home 5	Residence		er: Scene	
n of ding Pl After funera	on: 1	27. Manner of Death  1 ✓ Natural 5 P	ending	28a. Date of I (Month, Da	njury y,Year)	28b. Time o	' '	. Injury at Wo	_	28d. Describe	how injury	occurred		
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Certification:	2 Accident In	vestigation	28e. Place of	f Injury - At h	ome, farm, st	eet, factory, of					Number or F	Rural Route Number, City	
Div spital or cours aff	Certi	3 Suicide 6 Could not be determined (Specify)  9 Homicide or Town, State)  10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state-												
To the Hos within 24 h To the Fur	Medical	29a. Certifier (Check only one) 2 Medical E	xaminer:On	the basis of e	xamination a	ige, death occ and/or investig	curred at the tirgation, in my or	ne, date and pinion, death	place, and occurred at	due to the cau t the time, date	se(s) and r and place	nanner as st , and due to	ated. the cause(s)	
To T	Med	29b. Signature and title of certifier 29c. License number											fonth, Day, Year)	
		avet					(	D.C.M.E.			Octob	er 6, 200	9 ——	
12		30. Name and address of personal Ana Rubio MD.		oleted cause of Medical Ex		<sup>n 23a)</sup> 111 Penn	Street, Ba	Itimore, M	ID 21201		-			
	tate		2000	R. Regis	strar's Signal		de D							
Regis	tra	99103	PAAA	perm	a p	· Great	(1 <b>0</b> (5)			7.0.77				

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	Registrar	00 /First 141 1 11 - 1	Lant		Cei	rtificate of I	Death		2. Date of D	Reg. No	o.		) Z. U
in	1. Decedent's Nam	ne (First, Middle, I ne Bourde	•						Month 10-06-	Da		Ye <i>a</i> r	3. Time of Deat 734 P
al er			give street and numbe	r)		4b. City, Town, or	r Location	of Death	10 00	40	. County		
			lth & Reha			Forest H		04 Um 1			Harf		(0)
	5. Social Security 1	723	. Sex 7. A 1 □ M 2 X F	nge (In yrs. last 94	t birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	8. Date of Birth (Month, Day, Year) 12–03–1914			9. Birthplace (State or Foreign Country)	
	Usual Residence of 10a. State	10b. County		10c. City, T	Town or Lo	cation						1	10d. Inside City Lir
Ŝ	MD	Harf	ord	For	rest	Hill	.11						1 □ Yes 2 <b>)</b> 【
DIE	10e. Street and Nu		D			10f. Zip Code	- 0			10g. Citizen of What Cou			
runeral Director	109 For	est Vall	ey Drive	it Ever in U.S.	13. \	2105		igin? (Spe	ecify Yes or N	0-	14. Race	USA ce - American Indian,	
		ried 2 Married	Armed Forces	?		Was Decedent of H If Yes, specify Cuba			Rican, etc.)		Black	k, White,	etc.
2	3 XWidowed		Year or Dates	:	1 ☐ Yes 2X No Specify:						Specify: White		
Completed		15. Decedent's ecify only highest of	grade completed)		(Give	dent's Usual Occup kind of work done o DO NOT use retired	during mos	ng	16b. Kind of Business/Indu			ndustry	
5	Elementary/Second 12	ondary (0-12)	College (1-4o	Hous	e Wife			Ow	n Ho	me			
ם מ	17. Father's Name		,						e, Maidei	, Maiden Surname)			
<u> </u>		retschme						y Kir				O	
	19a. Informant's N		(Son)			ng Address <i>(Street</i> ingsarrow			l Lake			State, Zij	p Code)
	20a. Method of Dis			20b. Plac		sition (Name of natory or other place			2009	_		City or To	own, State
		☐ Cremation 3 5 ☐ Other (Spec	☐ Removal from Stat cify)	e		hs Cemete		-	2009	Sch	ienec	tady	NY
	21. Signature of F	uneral Service Lic	ensee		22	2. Name and Addre	ss of Facili	tySchi	imunek	Fune	eral :	Home	of BelA
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Medical Certification: To Be Completed by Physician/Medical Examiner	Sequentially list or if any, leading to in cause. Enter Undo Cause (Disease of that initiated event resulting in death)  IF FEMALE: 23b. Was deceder in the past 12 1	on o	b	is a consequent is a consequen	nce of):  nce of):  y eath 3 [ th 5 [  Noutpatier  Bb. Time of  Injury  e, farm, streedge, deatin and/or in	Ectopic pregnance Other (specify)  Int 3 DOA Oth  I	26. Place rer: 4 Nr. yat k? Yes 2 me, date a opinion, desenumber 3 2 2	e of Deathursing Ho	23e. Did  1	s an oppy formed?  Sidence how injution in the cause (a, date an appy).	Moruse contribution with the second of the s	Tibute to I	Interval Betwee Onset and Dea Dea Onset and Dea

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 6, 2009 October 22:00 Josephine Mary Butler /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Westminster

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year) | Navs | Min. | August 1, Carrol1 Carroll Hospital Center 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1914 1 □ M 2√□ F 95 Yrs 212-46-7981 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, I'm Modical Evanting must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 🕅 No Carroll MD Eldersburg Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21784 5907 Lawrence Road Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Test 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐Yes 2 X No Specify: White Specify: 3 XWidowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dora Lucido Salvatore Saia ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2111-304 Ganton Green Woodstock, MD 21163 Mr. Joseph R. Butler (Executor) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State All County Cremation | 10/8/2009 Sykesville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee HAIGHI FUNERAL HOME & CHAPEL, P.A. Drian Hayl M00764 | PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 2dans disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Ohstructzon Sequentially list conditions, if any, leading to inimediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of, spital or Attending Physician: The law requires that the death certificate be executed ours after death.

Heral Director: After this certificate has been signed by the aftending physician and filled in by the funceral director, page 2 should be detached for use as the burdar-fransit Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 **N**6 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 \( \text{Homicide} \) within 24 hours a

To the Funeral L 29a, Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number MO sel 52035 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

Baltimore, Maryland 21215-0036

Box 68760,

P.O.

Division of Vital Records,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** 16:50 **OCTOBER** 5, 2009 /Medical RICHARD GEORGE BARKKUME 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** UPPER CHESAPEAKE MEDICAL CENTER HARFORD BEL AIR If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Min 1**∑**M 2□F Director 24, 1925 New Jersey <u> 150-14-2603</u> Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ed other than "natural", or items 23a or 28a-f show event, the Medical Exteniner must be notified at 1 ☐ Yes 2 No Director Maryland Harford Forest Hill 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 301 Willrich Circle 21050 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1∑Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2√2 Married 21215-0036 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Owner / Operator <u>Real Estate</u> is marked other Maryland 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ntal George (nmn) Barkkume Marion Muscynska ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If item 27 any injury or other tr Olga Barkkume / Wife 301 Willrich Circle, Forest Hill, MD 21050 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 10/12/2009 Towson, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Rd., Abingdon, Maryland 21009 23a. Part 1. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** HUVES KUSP-E4-12My HOUTE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (of as a consequence of) sician and burial-tran Due to (or as a consequence of): Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 5 ☐ Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2 No 21 No 1 ☐ Yes 1 ☐ Yes **Division of Vital** 25. Was case referred to medical examiner?
1 ☐ Yes 2 No director Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of ne Hospital or Attending Pl n 24 hours after death. The Funeral Director: After to 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation 1 □Yes 2 □ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 29b. Signature title of certified 29c. License number 29d. Date signed (Month, Day, Year) 00056296 10-5-2009

State
Registrar

Kuma,

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Jason Birnbaum,

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

500 Upper Chesapeake Dr., Bel Air, MD 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 20c, per FH 6896 10/9/09 TT.

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10. State   10. County   10. City, from or location   10. City   10. Prince George   10. City   10. Prince George   10. City   10. Street and Number   13.205 Claxton Drive   13.205			029-14-3880	1 🗆	IM 2 <b>⊠</b> F	8	3 Yrs.	Months	Days	Hours	Min.	Oct.22	, 1925	5			
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17. Fether's Name (First, Middle, Last)   18. Mother's Name (First, Modele, Mache Surface)	ם		Elementary/Secondary (0-12	)	College (	1-4or 5+)			e retired	)			Otan	homo			
Sally Brandon / Daughter   19a. Mailing Address (Sweet and Number or Rural Route Number, City or Town, State. Zip Code)	ပ္ပ		17 Father's Name /First Midd	le I ast)	1	-	Homen	arei		18 Mothe	er's Name	(First Middle					
19a. Informant's NamerRelationship (Type Print)  19a. Informant's NamerRelationship (Type Print)  13205 Claxton Dr., Laurel, MD 20708  20a. Menhod of Disposition  WTRainfal 2   Cremation 3   Removal from State  4   Donation 5   Other (Specify)  12b. September 14   Pittsfield  12c. Informant's Namer Relationship (Type Print)  22. Super of Furuer State  22. Super of Furuer State  23c. Super State  22. Super of Furuer State  23c. Location Cy or Town, State  24c. Donation 5   Other (Specify)  25c. Super of State  25c. Super State  2	Be	5	_		rav								<i>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</i>	namo <sub>j</sub>			
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1   Yes 2   No 3   Probably 4   Munkr   24a. Was an autopsy performed? Injury season of the completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24a. Was an autopsy performed? Injury season of the completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24a. Was an autopsy performed? Injury season of the completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings availy prior to completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings availy prior to completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings availy prior to completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings availy prior to completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings availy prior to completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings availy prior to completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings availy prior to completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings availy prior to completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings availy prior to completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings availy prior to completion of cause death?   1   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings availy prior to completion of cause death?   1   Yes 2   No 4   Nursing Home 5   Residence 6   Other (Specify)   28b. Injury at Work?   1   Yes 2   No 4   Nursing Home 5   Residence 6   Other (Specify)   28b. Injury at Work?   1   Yes 2   No 4   Nursing Home 5   Residence 6   Other (Specify)   28b. Injury at Work?   1   Yes 2   No 4   Nursing Home 5   Residence 6   Other (Specify)   28b. Injury at Work?   1   Yes 2   No 4   Nursing Home 5   Residence 6   Other (Specify)   28b. Injury at Wo				L.													
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24a. Was an autopsy performed?   1   Yes   2   No   3   Probably   4   Munkr   24a. Was an autopsy performed?   1   Yes   2   No   3   Probably   4   Munkr   24a. Was an autopsy performed?   1   Yes   2   No   3   Probably   4   Munkr   24a. Was an autopsy performed?   1   Yes   2   No   3   Probably   4   Munkr	Z			2				7 7					23d	. Date of deliv	very		
1   Yes   2   No   3   Probably   4   Munkr   24a. Was an autopsy performed? In   Yes   2   No   3   Probably   4   Munkr   24b. Were autopsy findings avail prior to completion of cause death?   1   Yes   2   No   Norther   Norther   Norther   Norther   Norther   Norther   Nor	icia				4 🗌 Preg	nant at time of								Month	Day Year		
1   Yes 2   No 3   Probably 4   Munkr   24a. Was an autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24a. Was an autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24a. Was an autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and autopsy performed? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and prof to completion of cause death? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and prof to completion of cause death? In   Yes 2   No 3   Probably 4   Munkr   24b. Were autopsy findings available and prof to completion of cause death? In   Yes 2   No 3   Probable and prof to completion of cause death? In   Yes 2   No 3   Probable and prof to completion of cause death? In   Yes 2   No 3   Probable and prof to completion of cause death? In   Yes 2   No 3   Probable and prof to completion of cause death? In   Yes 2   No 3   Probable and prof to completion of cause death? In   Yes 2   No 3   Probabl	hys		9 🗆 Unknown		9 🗆 Unki	nown											
24a. Was an autopsy findings avail prior to completion of cause death? 1   Yes 2   No 3   Probably 4   Orker  24a. Was an autopsy performed to medical prior to completion of cause death? 1   Yes 2   No 1   Yes 2	-		Part II. Other significant cond	itions cor	tributing to d	eath but not res	sulting in the u	nderlying ca	ause give	en in Part I							
25. Was case referred to medical examiner?  1   Yes   2   No												1 🗆 1	res 2□N	lo 3□ Pro	bably 4 Vunkn		
25. Was case referred to medical examiner? 1   Yes   2   No	- Ω													4b. Were aut	opsy findings availa		
25. Was case referred to medical examiner? 1   Yes   2   No	5											perfo	rmed?	death?			
H0065661 October 5, 2009	Be (			-							of Death	(Check only o	ne)				
H0065661 October 5, 2009	၉				ص		<del>,                                     </del>		A	4 🗆 N					ify)		
H0065661 October 5, 2009	i o	ľ	1 Natural 5 ☐ Pen		28a. Date (Mor	of injury oth, Day, Year)	Injury					28d. Describe I	now injury o	ccurred			
H0065661 October 5, 2009	icat	!	3 ☐ Suicide 6 ☐ Cou	d not be	28e Place	of Injury - At h	ome farm str			res Z		Opt Location (Curs.)					
H0065661 October 5, 2009	erti		4 ☐ Homicide dete	rmined	build	ing, etc. (Speci	ify)	out, lactory.	, 011106			City or Tov	vn, State)	uniber of mur	ar rioute reuribei,		
H0065661 October 5, 2009	S S		29a. Certifier 1/ Certif	ying Phys	lcian: To the	e best of my kn	owledge, deat	h occurred	at the tin	ne, date ai	nd place,	and due to the	cause(s) an	d manner as	stated.		
H0065661 October 5, 2009	0 0		(Check only 2 Medic		ner: On the b	asis of examin											
H0065661 October 5, 2009	Q		29b. Signature and title of certi	fier				290	. License	number			29d. Date s	igned (Month	, Day, Year)		
	Med		1		100	656	661	1 4	Octob	055	2009						
	Med							1 1-4	UL				1				

			1 - For State Registrar	State of Mar	•	epartment Certificate			-	giene Reg. No.	2111	9 32	36
Н	Dhyaiai	00	1. Decedent's Name (First, Middle, Las	t)	-				2. Date of De Month		/ Year	3. Time of	Deeth
	Physici /Medio		JAMES PATRICK B						SEPTEM			9   5:20	Рм
Marie Sales	Examin	ier	4a. Facility Name (If not institution, give	· ·		,	vn, or Location	on of Death			County of De		
-	Funeral	-	NATIONAL INSTITI  5. Social Security Number 6. Se		LTH (In yrs. last birth	BETH		der 24 Hrs.	8. Date of Bir (Month, Da		MONTGOI 9. B	YERY irthplace (State o	or Foreign
	Director		220-56-3139	ZM 2∏F	9 Y	Months [	ays Hou	rs Min.	(Month, Da 9/8/19	3y, Year) 50		DC	
	pug 🔉		Usual Residence of Decedent  10a. State 10b. County		I Oc. City, Town o	r Location						10d. Inside C	ity Limits
	Maryle f sho	lor											2   No
	r 28a-	Director	MD Montgor  10e. Street and Number	nery	Gaith	ersburg 10f. Zip C	ode			10g. Citi.	zen of What C	ountry?	
	th witl 23a o 151 by		16924 Horn Point	Drive		2	0878			U	SA		
	r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Was Deceder If Yes, specify	t of Hispanic Cuban, Mexi	Origin? (Spican, Puerto	ecify Yes or No Rican, etc.)	)-	14. Race - An Black, Wh	nerican Indian,	
36	be filed within 72 hours after death with the Maryland that Hyglene.  dother than "natural", or items 23a or 28a-f show event, the Medical Exam har in at the multiple of event, the Medical Exam har in ust the multiple of	by Fi	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 No If Yes, Give Year or Dates:		1∐Yes 2¶x						White	
1215-0036	atural	ted k	15. Decedent's Ed	ucation	16a. D	ecedent's Usual (	Occupation			16b. Kir	nd of Busines	s/Industry	
212	hin 72 e. an "na Medi	ple	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5+)		Give kind of work of ife. DO NOT use	lone during n etired)	nost of worki	ing			1	
	filed wit Hygien Ither th	Completed		4 yrs		es Manag						Churchi	111
and	d tal	Be	17. Father's Name (First, Middle, Last)						e (First, Middle,		Surname)		
Ž	d 2 should the and Men Ith and Men 27 is marker traumatic	은	Jerre Blymyer  19a. Informant's Name/Relationship (7)	ivne Print)	10h M	failing Address (S	- 1		rshberg		r Town State	Zin Code)	
<u>8</u>	1 and 2 s Health ar em 27 is other trau		Patrice A. Blymye:		1	924 Horn							78
ë,	S to E		20a. Method of Disposition			isposition (Name crematory or othe			Date		cation - City o		
Ĕ	Pages ment of ant: If ite ury or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify			litan Cr		10/7	/2009	Alex	andria	, VA	
Baitimore, Maryland 2	permit. Page Department Important: If any injury or once.		21. Signature of Funeral Service Licens	see / /		22. Name and							
	40 = 40		one Plate Februaries discourse	Mall	/ Daniel	4217 Nin					ton, D		
			23a. Part. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.			-		or respiratory a	rrest,		Approximat Interval Bet Onset and	Death
Total Service	Physician /Medical		disease or condition resulting in death)	a. PROGRESSI			MULTI	FORME				2 YEAR	lS
1	Examiner			bue to (or as a c	sonsequence or,	•							
	დ ⊭	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated exerts)	Due to (or as a c	consequence of)	51'							
	ecute and -trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a c									
8/60,	requires that the death certificate be executed been signed by the attending physician and hould be detached for use as the burial-transit	alE			consequence or)								
200	ificate g phys	edical		d									
X Q Q	death certifica attending phate as ti	M/G	Zob. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2		3 ☐ Ectopic pred				2	23d. Date of d	elivery	
ם כ	e deat he att ied for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at til		5 ☐ Other (spec		***			Month	Day '	Year
<u>.</u>	law requires that the de as been signed by the 2 should be detached	Phy	9 ☐ Unknown  Part II. Other significant conditions co		not requiting in th	o undorluing sour	o given in De	we I	230 Did t	obacco II	see contribute	to the cause of o	lasth?
cords,	signe signe d be c	d by	Tartis. Other significant conditions of	naibuang to death but i	not resulting in the	ie underlying caus	e given iii ra	irt i.				Probably 4 🗓	
		letec							24a. Was		Τ	autopsy findings	
Ē	he law te has age 2 s	Completed							autor	psy rmed?	prior to death?	completion of c	
	lan. T	0	25. Was case referred to medical				26. Pl	ace of Death	1 X Yes	2 □ No one)	1 □ Y€	es 2 X No	
>	hysic his ce I direc	To B	examiner? 1 ☐ Yes 2 🏋 No	Hospital: 1 🗓 Inpatient	2 🗆 ER/Outp	atient 3 DOA	Othor:		me 5 ☐ Resi		6 □Other (Sp	ecify)	
Sion o	ing Pi	ou:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, )	/ear) 28b. Tin	ry	Injury at Work?		28d. Describe	how injury	y occurred		
20	ttend death stor: / the fi	icati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be	200 Diago of Jainey	A h f	M	1 ☐ Yes 2		006 1	- ·			
≥ :	effer effer Direc 3 in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	(Specify)	, street, factory, of	rice		City or To	Street and wn, State)	a Number or I )	Rural Route Nurr	nber,
	To the Hospital or Attending Physician. The law within 24 bours efter death.  To the Funeral Director: After this certifiliate has completely filled in by the funeral director page 2 of the page 3 o			sician: To the best of									
:	the H	ledical	(Check anly 2 Medical Exam	iner: On the basis of e					red at the time,	date and	l place, and di	ue to the cause(s	S) 
i	7 with 00	Σ	29b. Signature and title of Certifier	1/MA			cense numbe		9 VT			nth, Day, Year)	
	1.0		Mund	7				11 17	, V (		09/30/	cooy	
	V V		30. Name and a dress of person who c  ARGIRIOS MOUST.		tn (Item 23a) <b>(T)</b>		FNTFP	DRIVE	ВЕТИЕ	'SDA	MARVI	AND 2089	22
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's			LITTI	DVIAC	DEIDE	, אעטי	TIMILL	AND 2003	, _
	Registra	ar	OCT 0 9 20	09 Jenn	v A.	parkel							
DHM	H 17 Rev 1/20	001			,	W							

DHMH 17 Rev 1/2001

			for State Registrar		State of M	arylan		artment of rtificate o			ental Hy	/giene Reg. No	STUIT	32	352
	Physici	an	1. Decedent's Nam	ne (First, Middle, La	ast)						2. Date of De	Da	y Year	3. Time	
	/Medi		Eleanor	Alice B	roome					(	Octobe	r 5,	2009	4:30	Рм
	Examir	ner	4a. Facility Name	(If not institution, gi	ve street and number	)		4b. City, Town,	or Location	n of Death		4c	. County of Deat	h	_
- Alle				Leneagles				Silver	Spri				ontgome		
н	Funeral		5. Social Security !		Sex 7. Aq 1 □ M 2 💢 F		last birthday) Yrs.	If Under 1 Yea Months Day		er 24 Hrs. Min.	8. Date of Bi (Month, D	rth ay, Year)	9. Birt	thplace (State ountry)	
	Director		216-22- Usual Residence of	-2129		88	115.				August	16, 1	.921 Wash	ington,	D.C.
	land wc		10a. State	10b. County		10c. Cit	y, Town or Lo	cation						10d. Inside	City Limits
	Mary -f sh	ţ	Maryland	Montgon		C+1	*** C							1 □ Ye	s 2X No
	r 28a	irec	10e. Street and Nu		iery	211	ver Sp	10f. Zip Code				10g. Ci	tizen of What Co	untry?	
	3a o	Funeral Director	3200 G1	leneagles	Drive			2090	6			IIni	ted Stat	tes	
	death	ner	11. Marital Status		12. Was Decedent	Ever in U.	S. 13. \	Was Decedent of f Yes, specify Cu		Origin? (Spec	cify Yes or N		14. Race - Ame	rican Indian,	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evant at must be routified at once.	by Fu	1 X Never Mari 3 ☐ Widowed	ried 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		1	ryes, specify Cl 1 ⊡Yes 2 🛣 N			(ican, etc.)		Black, White Specify: Whi	•	
2-0	72 ho	Completed by	(Sno	15. Decedent's E	ducation		16a. Dece	dent's Usual Occ	upation	ant of worlds	_	16b. K	(ind of Business/	Industry	
21	thin Te.	d d	Elementary/Sec			5+)	life. L	kind of work don OO NOT use retii	e during me red)	ost or working	9				
2	ed wi	ပ္ပ			College (1-4or		Col1	Lege Ins	truct	or			Educatio	on	
Maryland	be file d oth even	Be	17. Father's Name	(First, Middle, Last	t)				18. Mot	ther's Name	(First, Middle	, Maider	Surname)		
yla	ould Men larke	ည		Warfield						annah 🛚					
lar	2 sh n and rism			lame/Relationship			1						or Town, State, 2		
	and Health			Lee Lodge	Cousin			Ho11y (	Jourt				laryland		
Baltimore,	ges 1 If of h or of		20a. Method of Dis		Removal from State	Dar	rlace of Dispo remetery, cren	sition <i>(Name of</i> natory or other pi Presbyter tery	lace)	Da			ocation - City or		
ţi	t. Pa rtmer rtant:			5 ☐ Other (Speci	· - Δ.	Chur							estown, Ma		
Bal	permi Depar Impor any ir		21. Signature of F	uneral Service Lice	11/1/1/1/	M0153	$\frac{1}{1}$	, Name and Add bert A. P O West Mc	ress of Fac umphrey ntgome	ility y Funera ry Aven	al Home, ue Rock	Rock ville	ville, Inc. Marylar	c. nd 20850	
			23a. Part 1. Enter shock, or hea	the disease, or con art failure. List only	plications that cause one cause on each li	d the death								Approxima Interval Be	ate etween
	Physician		Immediate Cause disease or condition	(Finai on	_a Cardia									Onset and	
	/Medical		resulting in death)	•	Due to (or as									- 111011	
	Examiner		Sequentially list co	enditions				lerosis						10 yea	ırs
	ed sit	Examiner	if any, leading to in cause. Enter Unde Cause (Disease or that initiated event	nmediate erlying	Due to (or as	a consequ	uence of):								
	tificate be executed g physician and as the burial-transit	хап	that initiated event resulting in death)	s Last	c Due to (or as	0.0000000	ionac of):								
60,	be e		,		Due to (or as	a consequ	derice or).								
68760,	icate phys	edical		•	d										
	eath certific attending p for use as		IF FEMALE:		23c. If yes, outcome	of pregna	incv						00d Data et dat		
Box	atter for u	Physician/N	23b. Was deceden	months?	1 ☐ Live birth 4 ☐ Pregnant a	2 Fetal	Ideath 3□	Ectopic pregnated of the control of				- 1	23d. Date of del Month	Day	Year
P.O.	tt the de by the tached	ıysi	1 □ Yes 2 i 9 □ Unknown		9 ☐ Unknown		, J_	Totaler (specify)							
	de de		Part II. Other signi	ficant conditions	contributing to death b	ut not resu	ulting in the ur	nderlying cause g	liven in Par	t I.	23e. Did	tobacco	use contribute to	the cause of	death?
of Vital Records,	quires n sign ald be	d by									10	Yes 2	Mo 3□ Pr	obabiy 4	Unknown
00	w requ	Completed									24a, Was	an	24b. Were au	tonsy finding	s available
Re	The la	щ									auto		prior to death?	completion of	cause of
ta	ian: T rtificat tor, pe		25. Was case refer	rred to medical					00 01-	D	1 Tyes	2 <b>X</b> No	1 □Yes	2 □No	
>	2 8 8	To Be	examiner? 1 □ Yes 2 🕅		Hospital:	ent 2 □	ER/Outpatien	1 3 D DOA O	41.	ce of Death		,	6 ☐Other (Spe	-:6 d	<del></del>
		n:T	27. Manner of Dear		28a. Date of Inju	ıry	28b. Time of	28c. Ini			3d. Describe			сіту)	
<u>.</u>	Attending Ir death. ector: After by the funer	atio	1 📉 Natural 2 □ Accident	5 ☐ Pending investigation	(Month, Da n	ıy, rear)	Injury		ork? ⊡Yes 2[	□No					
Division	after death after death Director: d in by the f	ific	3 ☐ Suicide 4 ☐ Homicide	6 Could not b determined		ury - At ho	me, farm, stre	eet, factory, office	)	28			nd Number or Ru	ıral Route Nu	mber,
Ö	tal or rs after al Dire	Certification:	+ EJ 1 lottilloide		Duliulig, et	c. (opecii)	"			- 1	City or To	wn, State	₽)		
	To the Hospital or , within 24 hours after within 24 hours after To the Funeral Directorpletely filled in L	Medical	29a. Certifier (Check only one)	1⊠ Certifying PI 2□ Medical Exa	hysician: To the best miner: On the basis o and manner st	of examina	wledge, death tion and/or inv	occurred at the restigation, in my	time, date opinion, d	and place, a eath occurre	nd due to the d at the time	cause(s , date an	s) and manner as d place, and due	s stated. to the cause	(s)
	<b>To th</b> e within 2 <b>To th</b> e сотрle	ž	29b. Signature and	title of certifier				29c. Licer	nse numbei	r		29d. Da	ate signed (Monta	h, Day, Year)	
			_ <b>&gt;</b> ()	MAB	MANN	^	21	D23	124			0ct	tober 7,	2009	
	101		30. Name and add	ress of person who	comp eted cause of c										
d	V			annon, M.				Spring	Rd.	#330 O	lney,	Mary	yland 20	832	- 17
	Sta Registr	te ar	31. Date filed (Mon	OCTU92	009 32. egistr	ar's Signal	ture.	ares							

Phys /Me Exa

Fune Direct

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Medical Evairing to a the redifficial at

Baltimore, Maryland 21215-0036

Physicia /Medica Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

101 Registrar

	1 - State Registrar					Cert	ificate	of D	eath			Reg. N	o. / [	119	3	235
	1. Decedent's Name	(First, Middle,	, Last)								Date of De     Month	ath _D	av	Year		e of Death
n al	Aud	rey Lo	uise Baye	er						0	Octobe	r 8,	200	)9.04	6:1	15 A M
er	4a. Facility Name (If I	not institution,	, give street and nu	ımber)			4b. City, To	own, or l	ocation	of Death		40	c. County	of Death	1	_
	Montgomer	v Hosp	ice Case	y Hou	se			Roc	kvil	.1e		M	ontg	omer	У	
	5. Social Security Nu		6. Sex	7. Age (II	n yrs. last bir		If Under 1	Year	If Under	24 Hrs.	8. Date of Bir	th	.)			ate or Foreig
	578-22-15	98	1□M 2፟፟፟IF	8	35	Yrs.	Months	Days	Hours	Min.	(Month, De	¥ 4,	(923	Washi	ngton .	, D.C.
	Usual Residence of D	Decedent									ecembe	_				
	10a. State	10b. County		10	c. City, Towr	or Loca	ation								10d. Insid	e City Limits
5	Maryland	Vortee	m 0 *** V				Pot	omac							12	Yes 2□No
3	10e. Street and Numb						10f. Zip (					10a C	itizen of	What Cou	intry?	
i	9716 Cone		Mori					2085	/,					Stat		
3	9710 Cone	SLUga														
I dileiai Dilectoi	11. Marital Status		12. Was Dec Armed F	orces?	rin U.S.	13. W	as Decede Yes, specif	nt of His fy Cubar	panic O , Mexica	rigin? (Spec in, Puerto F	cify Yes or No Rican, etc.)	)-		ce - Amer ck, White,	ican Indiar etc.	n,
Jy L	1 Never Marrie		ed 1 □Yes If Yes, G	2 <b>⊠</b> No ive		11	□Yes 2	No No	Specify	<i>'</i> :			Specif	w. Wh	ite	
	3 X Widowed 4	∐Divorced	Year or I	Dates:												
2	(Specif	15. Decedent's	's Education t grade completed)		16a.	(Give ki	ent's Usual and of work	done de	ırina mo:	st of workin	a	16b. l	Kind of B	lusiness/li	ndustry	
completed	Elementary/Second	<del></del>	<u> </u>	1-4or 5+)		life. Do	O NOT use	retired)	5		5	_	_	_		
	12				Se	cret	ary					C	hurc	h		
2	17. Father's Name (F	First, Middle, L	ast)						18. Moth	er's Name	(First, Middle	, Maide	n Surnaı	ne)		
	Joseph	Hugh H	ur1ey						Ar	ina Wa	lters					
	19a. Informant's Nan	ne/Relationsh	nip (Tvpe, Print)		19b	Mailing	Address (	Street a	nd Numb	er or Rural	Route Numb	er. Citv	or Town	. State. Z	ip Code)	
	Carolyn B			aught							erwood	-				,
	20a. Method of Dispo				20b. Place of										own, State	
			3 ☐ Removal from	State	Gate o	y crema	tory or oth	ner place	) (		13,			•		
	4 □ Donation 5	5 ☐ Other (Sp	pecify)		Cem	etei	CA		- 1		09					aryland
	21. Signature of Fun	eral Service L	icensee	,		P 22.	Name and	Addres	of Facil	ity Bake	Tt A. Westo <sup>M</sup>	Pum	phre	y Fu	neral	Home
	100	7-2	whit	M01	498	Roo	kvii.	Īē,	Mary	land	26850°	iont	gome	ry A	venue	
1	23a. Part 1. Enter the	e disease, or o	complications that	caused the	death. Do r										Approxi	imate
	shock, or heart Immediate Cause (F	failure. List o	complications that	Hodgl	cin											Between and Death
	disease or condition resulting in death)		a. Non	Hodg.	<del>ken</del> -Ly		oma									
	,		Due to	(or as a co	onsequence	of):								i		
	Sequentially list cond	ditions,	D		rforat											
	Sequentially list cond if any, leading to imm cause. Enter Underly Cause (Disease or in	nediate ying	Due to	(or as a co	onsequence	ot):										
	i that initiated events		С													
	resulting in death) Last  Due to (or as a consequence of):															
			d													
	IF FEMALE: 23b. Was decedent p	nregnant	23c. If yes, ou			_							23d. Da	ate of deli	very	
	in the past 12 m	nonths?			Fetal death ne of death		Ectopic pre Other (spe							onth	Day	Ye ar
	1 □ Yes 2 🛭 9 □ Unknown	OVI	9 ☐ Unk			, _										
		ant condition	ns contributing to a	death hut n	ot resulting in	the unc	derlying car	use dive	n in Part	I.	23e. Did	tobacco	use con	tribute to	the cause	of death?
ì	Part II. Other signific	brilla	tion	20001120011	or roouning ii	1110 0110	onymg ou	acc give								
	Atrial <del>Fi</del> Venou	<del>brilat</del> IS	<del>10n</del>								1	res .	2   140	3 L FI	Juaniy 4	Unknow
	Deep <del>Vein</del>	Throm	bosis								24a. Was		24b.	Were au	topsy findi	ngs availabl
												rmed?	.	death?		of cause of
	25. Was case referre	ed to medical							OC Dias	of Dooth	1 □ Yes		10	1 ∐ Yes	2 No	
	examiner?		Hospital:					Othe			(Check only		Но	spic	e In	patien
	1 Yes 2 N				2 ER/Ou	tpatient Time of		٦	4 L N		ne 5 Res				ify)	
	27. Manner of Death 1 K Natural	5 Pending		nth, Day, Ye		njury		ic. Injury Work			8d. Describe	how inj	ury occu	rred		
	2 Accident	investiga 6 Could n					M	1 □Y	es 2	]No						
	3 ☐ Suicide 4 ☐ Homicide	determin	ned 28e. Place	e of Injury	- At home, fa Specify)	rm, stree	et, factory,	office		2	8f. Location ( City or To	Street a	and Num	ber or Ru	ral Route	Number,
											,	,	,			
			g Physician: To th													(-)
	(Check only 2 one)	∠ medical E	Examiner: On the land man	basis of ex nner stated		u/or inve	ssugation,	in my op	union, de	eath occurre	ed at the time	, date a	na piace	, and due	to the cau	se(S)
	29b. Signature and ti			-			29c.	License	number			29d. D	ate sign	ed (Month	, Day, Yea	ar)
	1. K	oudt	chou,	MD			ا لما	637	48			0ct	ober	8,	2009	
					(1)	ing.						J 0 E	5501	-,		
	30. Name and addres							ad +	Dan	lerro	D o 1 + -	m c ==	o M	0.25-7	and 1	1210
			tchou, M			LUI	iiver	SILA	rar	kway,	Dalti	mor	e, M	aryı	and 4	.1210
	31. Date filed (Month	n, Day, Year)	32.	Re day's	Signature		1 2	0								
1		OCTO	9 2009	lever	U B.	A	are									
			14000	111		\$ 67										

			For	partment of Health and I Certificate of Death	dental Hygiene Reg. No. 🤈	2009 32361
	Physicia		1. Decedent's Name (First, Middle, Last)  Gregory Scott Bengough		2. Date of Death Month Day September 26	3. Time of Death 5, 2009 4:30 PM
	/Medic Examin Funeral		4a. Facility Name (If not institution, give street and number) 4 Veitch Court 5. Social Security Number 6. Sex 7. Age (In yrs. last birtha	Months Davs Hours Min.	4c. Co	sounty of Death altimore  9. Birthplace (State or Foreign Country)
	Director mou		216-82-5616		Oct 2, 1959	10d. Inside City Limits
	with the Mar a or 28a-f sl	Director	MD Baltimore Balt:  10e. Street and Number  4 Veitch Court	imore   10f. Zip Code   21236		1 □Yes 2√ No en of What Country? USA
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it in "Midfiel Ergini har must be neitled at once.	by Funeral		13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 □ Yes 2 No Specify:		4. Race - American Indian, Black, White, etc. Specify: white
Maryland 21215-0036	within 72 hou iene. than "natura he Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of wor fe. DO NOT use retired) Lintenance worker	king	d of Business/Industry
yland 2	ould be filed   Mental Hygi   Marked other   Marked other	To Be Co	17. Father's Name (First, Middle, Last)  Larry Wayn Bengough	18. Mother's Nan Linda M	ne (First, Middle, Maiden Si arie Wallenbo	Gurname) Orn
re, Mar	s 1 and 2 sh of Health and item 27 is m other traum		Therese Carol Terzakis/sister 4 120a. Method of Disposition 20b. Place of December 120b. Place 120b. P	Mailing Address (Street and Number or Ru Veitch court Baltim isposition (Name of crematory or other place)	ore, MD 212	
Baltimore,	permit. Pages of Department of I Important: If ite any Injury or of once.		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signatur of Juneral Service Licensee  Analy Symbol Wade Nirgetor	22. Name and Address of Facility State Anatomy Board		timore Street
	Physician	6 1	23a. Partit. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. Immediate cause (Final disease or common to not common to the cause of the common to the cause or common to the cause or common to the cause of the cause	enter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death
58760,	The law requires that the death certificate be executed and ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit and a signed by the detached for use as the burial-transit and a signed by the detached for use as the burial-transit and a signed by the detached for use as the burial-transit and a signed by the detached for use as the burial-transit and a signed by the detached for use as the burial-transit and a signed by the detached by	edical Examiner	disease or chapton resulting in death)  Sequentially list conditions, flarly, leading to ministrate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  a. Due to (or as a consequence of)  b. Due to (or as a consequence of)  c. Due to (or as a consequence of)  d.			
O. Box (	the death certifi y the attending   ched for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23	3d. Date of delivery Month Day Year
rds, P.	w requires that the de been signed by the should be detached f	þ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobacco us 1 ☐ Yes 2 ☐	se contribute to the cause of death?  No 3 Probably 4 Unknown
Division of Vital Records,	n; The law re ficate has be rr, page 2 sho	Completed	25. Was case referred to medical	an Plant de	24a. Was an autopsy performed? 1 □ Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death?  1 ☐ Yes 2 ☐ No
of	Physicia rrthis cert rral directo	To Be	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp  27. Manner of Death 28a. Date of Injury 28b. Tin	atient 3 DOA Other: 4 Nursing F	lome 5 Residence 6 28d. Describe how injury	
ivision	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Certification: To	1	M 1 ☐Yes 2 ☐ No	28f. Location (Street and City or Town, State)	f Number or Rural Route Number,
_	Hospital 24 hours a Funeral etely filled	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, 2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and plac or investigation, in my opinion, death occ	e, and due to the cause(s) urred at the time, date and	and manner as stated. place, and due to the cause(s)
þ	To the within To the compl	Me	29b. Signature and title of certifie	29c. License number H005717	_   .	e signed (Month, Day, Year)
		9 19		rpe, Print) LANEL(14)A RX	STE \$314	
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature	land		21237

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #30 per DVR 8896 10/2/09 TT

			1 - State of Maryland / Der	partment of Health and N Pertificate of Death		ene a.No. 2000 - 2000
	Dhyoio	25	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month	3. Time of Death
	Physici /Medi		Khiam Chew		October	$\frac{7}{7}$ , $\frac{2009}{9}$ 12:15 A <sup>M</sup>
	Examir	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
Ŧ	Funeral		Anne Arundel Medical Center  5. Social Security Number   6. Sex   7. Age (In yrs. last birthda)	Annapolis  of Under 1 Year   If Under 24 Hrs.	8. Date of Birth	Anne Arundel  9. Birthplace (State or Foreign
	Director		079-82-4856 1X M 2□F 95 Yrs.	Months Days Hours Min.	July 19,	1914 China
	pu.		Usual Residence of Decedent		pary ry	
	faryla sho	ō	10a. State   10b. County   10c. City, Town or to the state   10c. City,			10d. Inside City Limits 1 X Yes 2 □ No
	the A	Director	10e. Street and Number	10f. Zip Code	100	a. Citizen of What Country?
	h with	al Di	3909 New Haven Court, Apt. B6	20716	100	U.S.A.
	ems ?	Funeral		. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - American Indian,
36	172 hours after death with the Maryland "natural", or items 23a or 28a-f show valcel Examiner must be notified at	by Fu	1 ☐ Never Married 2 🔀 Married 1 ☐ Yes 2 🛣 No If Yes, Give	1 ☐ Yes 2 X No Specify:	rican, etc.)	Black, White, etc.  Specify: Asian
9	hour tural	ed b	3 ☐ Widowed 4 ☐ Divorced	edent's Usual Occupation	14	Sb. Kind of Business/Industry
215	hin 72 e. an "na Medi	Completed	(Specify only highest grade completed) (Giv Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of work DO NOT use retired)	ing	bo. Rind of Business/Industry
2	ed wit ygien er tha	Con	12 Tai	lor		Clothing
nd	be file	Be	17. Father's Name (First, Middle, Last)		e (First, Middle, Ma	tiden Surname)
ryla	hould d Mer marke matic	욘	MuiWah Chew  19a. Informant's Name/Relationship (Type. Print)  19b. Mai	SoonEng		
Ma	nd 2 sulth an 27 is r			ling Address <i>(Street and Number or Rur</i> 308 Skylark Lane <b>,</b>		
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, It e Medical Once.		20a. Method of Disposition 20b. Place of Disp			Oc. Location - City or Town, State
Ē	Page ment c ant: If ury or		I L Dunai 2 M Cientation 3 L Removal from State 1	mation Services 10/0	8/2009 F	Janover Maryland
3alt	eparti eparti nporti ny inji		21. Signatur - Funeral Service Lic nsee	22. Name and Address of Facility Arc	dent Crem	ation Services
	20 <b>5 6 9</b>			7522 Connelley Driv		
			23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.			t, Approximate Interval Between Onset and Death
	Physician // Medical		Immediate Cause (Final disease or condition resulting in death)  a. http://www.ac.ac.ac.ac.ac.ac.ac.ac.ac.ac.ac.ac.ac.	respiratory gail	ure	2 days
	Examiner		Dul to (or as a consequence of):	0.0		
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence on):			
	ecuter Ind transi	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		-	
60,	be exician a	Ě	resulting in death) Last Due to (or as a consequence of):			
68760,	rtificate be executed ng physician and as the burial-transit	edical	d			
Box (	eath certif attending for use as	Me.	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date of delivery
ω̈́.	death e atte	Physician/M	in the past 12 months?  1	☐ Ectopic pregnancy ☐ Other (specify)		Month Day Year
P.O.	at the de by the stached	hys	9 ☐ Unknown 9 ☐ Unknown			
s,	res tha signed be det	þ	Part II. Other significant conditions contributing to death but not resulting in the t	Inderlying cause given in Part I.	23e. Did tobac	cco use contribute to the cause of death?
000	w requires been si should I	eted	CVI		1 ☐ Yes	2 No 3 Probably 4 Unknown
Rec	ne law e has l ge 2 s	Completed			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
ta E	sician: The certificate h rector, page		25. Was case referred to medical			d? death? ☐No 1 ☐ Yes 2 ☐ No
$\geq$	ysicia is cert direct	To Be	examiner?  Hospital: 1 Inpatient 2 ER/Outpatie	26. Place of Death		ce 6 □Other (Specify)
Division of Vital Records,	ng Ph fter th neral	Ë.	27. Manner of Death 28a. Date of Injury (Month, Day, Year) Injury Injury		28d. Describe how	
Sio	tendii eath. or: A the fu	catic	2 Accident investigation 3 Suicide 6 Could not be	M 1 ☐ Yes 2 ☐ No		
<u>&gt;</u>	or At after d Direct in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rural Route Number, State)
_	spital		29a. Certifier Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the cou	co(s) and manner of stated
	To the Hospital or Attending Physician: The law requires that the death certiful to thours afterdeath  To the Funeral Director. After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurr	red at the time, date	e and place, and due to the cause(s)
	vithi To th	Ž	29b. Signature and title of certifier	29c. License number	29d	. Date signed (Month, Day, Year)
			Illorusa & ren	H065117	M	7/7/09
			30. Name and address of person who completed gause of death (Item 23a) (Type,			
	Stat		Monica Saenz, MD Anne Arundel Medical 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature	Ctr. 2001 Medical	Pkwy. An	napolis, MD 21401
	Registra		0000	a del		

DHMH 17 Rev 1/2001

			For _ State	State of Ma	ryland				and M	ental Hyg	jiene	0.0	10	250
		Registrar  1. Decedent's Name (First, Middle, Last)  2. Date of Dea											3. Time of	J J J
*	Physicia Medic		Ruth	Crawford	E					Month 10 2	Day	Year	12:0	
	Examin	er	4a. Facility Name (if not institution, g				4b. City, Town,		of Death		4c. Count			
7	Funeral		Stella Mari  5. Social Security Number 6		(In vrs. la:	st birthday)	Tows		24 Hrs.	8. Date of Birth			more	r Foreign
,	Director		212-20-9373	1 □ M 2 <b>X</b> F	85	Yrs.	Months Day		Min.	(Month, Day,		Cou		
11	od te	_	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Loc	ation					—Т	10d. Inside Ci	ty Limits
	larylar 3a-f sl ified	Funeral Director		/A	-	ltimo								2 🗆 No
	the M or 28	Ö	10e. Street and Number				10f. Zip Code	)			10g. Citizen of	What Cou	intry?	
	s 23a	hera	1609 E. Bid	dle Street			21	.213			Ţ	JSA		
Ė	death r item iner n	/ Fui	11. Marital Status	12. Was Decedent Ev Armed Forces?		. 13. W	as Decedent of Yes, specify Cu	Hispanic Or ban, Mexica	igin? (Spec n, Puerto R	cify Yes or No- Rican, etc.)		ce - Ameri ick, White	can Indian, etc.	
12:04 a.m 21215-0036	within 72 hours after death with the Maryland giene. er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at	d by	1x Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	d 1 ∐ Yes 2 🕱 N If Yes, Give Year or Dates.	0	1	☐ Yes 2 🙀 N	lo Specify			Specify	Bla	ck	
2:04	hour 'natur	plete	15. Decedent's (Specify only highest	s Education grade completed)		16a. Decede	ent's Usual Occi	upation	et of workin	16b. Kind of Business Industry				
12:	thin 72 ine. than '	Be Completed	Elementary/Seconday (0-12)	College (1-4 or 5+	)	life. DC	NOT use retire	d)		9	Montrose School			
	filed wi al Hygie d other vent, tl		12th 17. Father's Name (First, Middle, Las	2yrs				18. Moth	er's Name	(First, Middle, N	_			
2009 ryland	d be fi Mental arked atic ev	ပ	Benjamin	F. Cra	wfo	rd			Ceil:	ia		Co	llins	
2, Ma	d 2 should alth and Me 127 is mar er traumati		19a. Informant's Name/Relationship Bright Blufo			19b. Mailing 160	g Address <i>(Stree</i> 9 <b>E</b> E	et and Numb Biddle	er or Rural e St	Route Number, Balt	City or Town,	State, Zip , MD	<sup>Code)</sup> 21213	3
OCTOBER Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1       Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spe		20b. Pl	ace of Dispos metery, crem butus	ition (Name of atory or other p. Mem.	Pk.	10/10	ate 0/09	20c. Location	-		MD
OCTO Balti	permit. I Departm Importa any inju		21. Signature of Funeral Service Lice	ensee Wane			Name and Add	ress of Facili	ty MAE	RCH FU	NERAL Balti	HOM	E-EAS	21202
×			23a. Part 1. Enter the disease, or co shock, or heart failure. List only		he death	. Do not enter	the mode of dy	/ing, such as	cardiac or	respiratory arre	est,		Approximat Interval Bet	e ween
	Physician/		Immediate Cause (Final disease or condition	_ a COLON CA	NCE	R							Onset and I	
	Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):								
		ner	Sequentially list conditions, if any, leading to immediate	quentially list conditions, b. ———————————————————————————————————										
W	executed an and rial-transit	kami	that initiated events	С.								74		
6.	cate be executed physician and s the burial-transit	dical Examiner	resulting in death) Last	Due to (or as a	conseque	ence of):								
760	75	w		d										
Box 687	death certificate ne attending physed for use as the	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	f pregnan	ncy	Ectopic pregna	ancv			23d. D	ate of deli	very	
	he death y the att	hysici	in the past 12 months? 1 ☐ Yes 2 <b>X</b> No 9 ☐ Unknown	4 Pregnant at 1 9 Unknown			Other (specify)				M	onth	Day	/ear
B.O.	s that t gned b	by P	Part II. Other significant conditions	s contributing to death but	t not resu	ulting in the ur	nderlying cause	given in Part	1.		bacco use con			
WFC rds	equire	eted					<u> </u>			14	es 2 No			
RUTH CRAWFORD Vital Records, P.	The law and the law and the last bage 2 s	FFEMALE:   23b. Was decedent pregnant in the past 12 months?   1											ompletion of c	
RUTH Vital F	cian: ertifica ector,	Be	25. Was case referred to medical examiner?	Hospital:				Place of Dea	ath (Check					
	Physi this c	2	1 ☐ Yes 2 <b>X</b> No  27. Manner of Death	1 Inpatier		ER/Outpatient	3 LI DOA			ne 5 Reside			HOSP	ICE
	27. Manner of Death  28a. Date of injury  (Month, Day, Year)  28b. Time of injury  a work?  1 X Natural 5 Pending  2 Accident Investigation  28a. Date of injury  M 1 Yes 2 No										reu			
Division	or Atter	Certificate:	3 Suicide 6 Could no 4 Homicide determine	t be 28e Place of Injur	y - At hor (Specify)	ne, farm, stre	et, factory, offic	e	2	28f. Location (St City or Town		per or Rura	al Route Numb	per,
	To the Hospital or Attending Physician: The law requires that the dewinthin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the acompleted filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 Medical Exa	hysician: To the best of maminer: On the basis of exa	amination	and/or investi	gation, in my opi	nion, death o	ccurred at t	the time, date an	nd place, and di	ue to the c	ause(s) and ma	nner stated.
le	To the within 2 To the comple	Ň	only one) 3 X Certifying N 29b. Signature and title of certifier	lurse Practioner: To the b	est of my	knowledge, d		the time, dat	e and place		cause(s) and n 29d. Date signe			
			1 Strong	3 CRNP			KI	4979	12		102	200	9	
			30. Name and a dress of person wh	CDND 2300 1	DITT AT	MEA AV.	מם אמוו	<b>ም</b> ፐህ	MITIM	MD 2	1093			
	Stat		31. Date filed (Month, Day, Year)	32. Registrar	s Signatu	ure have	W IN	, LIL	CHILDE		-0/3			
	Registra	ar	OCT 09 200	10 Heren	Ju.	17								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death  $1^{\mathsf{Day}}$ Physician/ Month 2009 2p. М Michelle Chance Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1139 Scott Street N/A Baltimore If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex Birth Country) 8. Date of Birth '. Age (In yrs. last birthday) **Funeral** Month, Day, Min. 1 🗆 M 2🏋 F 37 Director 082-60-4490 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1139 Scott 21230 Street death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes ★★ No If Yes, Give Baltimore, Maryland 21215-0036 within 72 hours after 1 Yes 2 X No Specify: Specify: "natural", 3 🗌 Widowed 4 🗆 Divorced Black Completed Year or Dates event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 2yrs self employed N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Greenidge Beverlev Lennox Constantine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Chance-husband 1139 Scott St. Baltimore, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 10/10/09 Woodlawn Cemetery Baltimore 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MARCH FUNERAL HOME-EAST wa on E. Avenue Baltimore -North-23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physiciani METASTASIS BREAST CANCER disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate Examine Districtor on a nonsequence of): cause. Enter Underlying Cause (Disease or iinjury that initiated events the Hospital or Attending Physician: The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 the attending plant the thick the state of t IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months? Dav Year signed by the a Id be detached for **X**No 1 L Yes 41 9 D Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an cate has I page 2 s prior to completion of cause of death? performed? Yes 2 X No 2 🗌 No certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 2 XNo 1 🔲 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home XX Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dil 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending Natural 1 🗌 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

State Registrar

31. Date filed (Month, Day, Year)

OCT 0 9 2009

29a. Certifier (Check

only one) 29b. Signature a Certifying Nu se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Paca Street Baltimore, MD 21201

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month :454 Medical 4a. Facility Name (if not institution, give 4b. City, Town, or Location of Death **Examiner** 4c. County of Death timo 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign
Country) **Funeral** Months Hours Min. 219-30-218 Usual Residence of Decedent Director 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at **Funeral Director** Amore 1 Yes 2 No 0 et and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò Completed by 1 Never Married 2 Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No "natural" 3 Widowed 4 Divorced 1acl 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event "to once." (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 8. Mother's Name (First, Middle, Maiden Surname) မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20a Metho 20b. Place of Disposition (Name of gemetery, crematory or other place) of Disposition 1 MBurial 2 Cremation 3 Removal from State butus 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Greene Himore Part 1. Enter the disease, or commications that caused the death. Disno shock, or heart failure. List only one cause on the line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to lor as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to a a la cor 140M9 that initiated events resulting in death) Last Due to (or as a consequence Certificate: To Be Completed by Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months?

1 Yes 2 No Month Dav Year 9 Unknown P.O. ntributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 No 2 No 1 🗌 Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Director: After work? 1 🔲 Yes 1 Natural 5 Pending within 24 hours after death To the Funeral Director. A Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only or 29b. Signa

Registrar

State

ompleted cause of death (Item 23a) (Type, Print)

			For State Registrar	State o	f Maryland	•	artment of I		d Mental Hyg	jiene Reg. No.	009	32369	
			Decedent's Name (First, Middle,	Last)			2. Date of Dea			3. Time of Death			
	Physicia		Hilma I	M.	C	rutchm	an		Month 10	03 <sup>y</sup>	2009	9:00P M	
	Medic Examin		4a. Facility Name (if not institution,	give street and num	ber)		4b. City, Town, o	Location of De	eath	4c. Cou	nty of Death		
		•	Sunny Woods As:	sisted Li	ving		Westmi	nster		Car	roll		
	Funeral		5. Social Security Number	S. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year Months Days			Voorl	9. Birthplace (State or Foreign		
	Director	l	213-28-8810	1 □ M 2 🙀 F		76 Yrs.	Months Days	Hours	10-25-	1932	Mar	yland	
	d t ow	_	Usual Residence of Decedent  10a. State 10b. County		Inc. City	, Town or Lo	cation				1	0d. Inside City Limits	
	urylan a-f sh ied a	cto		1.1	1						Ι.	1 🗆 Yes 2 🔯 No	
	r 28g	声	MD Ca	rroll	N N	lestmin	10f. Zip Code			10a Citizen	of What Coun		
	/ith th	la	821 Knobs End	Drive				.158		USA		,.	
	ems r mu	Funeral Director	11. Marital Status		dent Ever in U.S	. 13. V	Vas Decedent of H	ispanic Origin?	(Specify Yes or No- erto Rican, etc.)	14. F	Race - Americ	an Indian,	
9	ter de or it	by F	1 Never Married 2 Marrie		2 😡 No				ierto Rican, etc.)		Black, White, e		
9	urs af ural", il Exa	pe	3 ₩ Widowed 4 □ Divorced	If Yes, Giv Year or Da	e ites.		☐ Yes 2 🙀 No	Specify:		Spec	whit	e	
5	72 ho	ple	15. Decedent (Specify only highes			(Give I	lent's Usual Occup kind of work done	during most of t	working	16b. Kind o	f Business Ind	dustry	
72	ithin ithin the man	Completed	Elementary/Seconday (0-12)	College (1	-4 or 5+)		O NOT use retired) okkeeper			Real 1	Estate		
9	ed w Hygi othel ent, i	l as l	17. Father's Name (First, Middle, La	st)				18. Mother's	Name (First, Middle, I				
an	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	욘	Frederick	Mes	enbrink				tha Spieg		,		
ary	hould and N s ma umat		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailir	ng Address (Street	and Number or	Rural Route Number,	City or Town	n, State, Zip C	Code)	
Σ	id 2 sealth san 27 i		Kevin Haven, S	on		821	Knobs En	d Drive	, Westmins	ster,M	D 2115	8	
Baltimore, Maryland 21215-0036	of He of He if item ir oth		20a. Method of Disposition  1 A Burial 2 Cremation	3		lace of Dispo	sition (Name of natory or other place	ce)	Date	20c. Location	on - City or To	wn, State	
<u>Ĕ</u>	Page ment lant: I	Ш	4 Donation 5 Other (Sp		Ba1	timore	Nationa	1 10/	9/2009	Balt <u>i</u> m	ore, M	aryland	
3alt	permit Depart Import any inj once,		21. Signature of Funeral Service Liv	censee	Majos	30 P1	Name and Addre	ss of FacilityS	terling As Catonsvill	hton in	Schwab	Witzke	
ш			7	Hade			630 Edmoi	idson A	<u>venue: Cat</u>	onsvi	11e, M	n 21228	
			23a. Part 1. Enter the disease, or o shock, or heart failure. List or	omplications that only one cause on ea	caused the death chaine.	-	[	1		est,		Approximate Interval Between	
	Pnysician/ Medical	7.14	Immediate Cause (Final disease or condition resulting in death)	_ aA	-12h	21m	ers	De	mont	19		Onset and Death	
	Examiner		resulting in death)	Due to	or as a consequ	ence of):		-				/	
		Jer	Sequentially list conditions, if any, reading to immediate	b. — Due to	Desiron sissing	ents of							
	ted 1 Insit	ᇤ	cause. Enter Underlying Cause (Disease or iinjury	_									
	execu an and ial-tra	Ë	that initiated events resulting in death) Last	Due to	or as a consequ	ence of):							
00	icate be executed g physician and is the burial-transit	dical Examiner	•	d									
6876	tificat ng ph as th	Mec	IF FEMALE:										
9 ×	th cer tendi	ian/	23b. Was decedent pregnant in the past 12 months?	1 🔲 Live	come of pregnal Birth 2 🗆 Feta	Ideath 3	Ectopic pregnan	Су			Date of delive	ery Day Year	
Вох	e deat the at ned fo	Physician/Me	1  Yes 2 No 9 Unknown	4 ∐ Preg g ☐ Unkr	nant at time of d nown	leath 5∟	Other (specify) _				MOHIII	Day lea	
P.O.	Attending Physician: The law requires that the death certificate be executed ar death.  ector: After this certificate has been signed by the attending physician and by the funeral director, page 2 should be detached for use as the burial-transit		Part II. Other significant condition	ns contributing to d	eath but not resi	ulting in the u	ınderlying cause gi	ven in Part I.	23e. Did to	bacco use c	ontribute to th	ne cause of death?	
S, F	ires the signer of signer of the signer of t	d by							_ 1 🗆 \	es 2 N	o 3 🗆 Prot	bably 4 🗆 Unknown	
Division of Vital Records,	v required should be shoul	Completed							24a. Was a		b. Were auto	psy findings available	
Sec.	ysician: The law is certificate has director, page 2	E O							— autop perfor 1 ☐ Yes	med?	death?	mpletion of cause of	
a F	Ician: The certificate ector, pag	BeC	25. Was case referred to medical				26. P	lace of Death (0	Check only one)	2 2 110	1 103	Assisted	
Zit	nysici lis cer direc	To E	examiner? 1  Yes 2 1 No	Hospital:	Inpatient 2	ER/Outpatier	nt 3 🗆 DOA Oth	er: 4 🗌 Nursir	ng Home 5 🗆 Resid	ence 6	Other (Specify	Living	
of	ng Pł fter tł ineral		27. Manner of Death 1 → Natural 5 → Pending	28a. Date (Mon	of injury th, Day, Year)	28b. Time of injury	wor	₹?	28d. Describe h	ow injury occ	curred	J	
ioi	tendi leath, lor: A the fu	ijį	2 Accident Investig	ation of be				Yes 2 ☐ No					
ivis	or At after of Direction by	Certificate:	4 Homicide determine	28e. Place	of Injury - At ho ng, etc. (Specify,		eet, factory, office		28f. Location (S City or Town		mber or Rural	Route Number,	
	To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral		29a. Certifier 1 Certifying	Physician: To the b	est of mv knowl	edge, death	occured at the time	e, date and place	e, and due to the cau	ise(s) and ma	anner as state		
	e Hos	Medical	(Check 2 Medical Ex	aminer: On the bas	sis of examination	and/or inves	tigation, in my opini	on, death occur	red at the time, date ard place, and due to the	nd place, and	due to the car	use(s) and manner stated.	
	To the within 2	-	29b. Signature and title of certifier	m/			29c. Licens	e number	200	- 2 3	ned (Month,	Day, Year)	
			Mobert	11/66	n- 11	11	D	542	18	octok	ier 8	12000	
	,		30. Name and address of person w	ho completed caus	se of death (Item	23a) (Type, F	Print)	01	P 1.10-	Ĺ	in	MA DIKE	
			31. Date filed (Month, Day, Year)	135, 160	gistrar's Signat		m Drive	>uite	c wes	TMINS	Ter !	W 203/	
	Sta Registra		OCT 0 9		remain a signal	A. 1	arked.						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 9 3 9 7 1 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCTOBER 8, 2009 ELSIE MITCHELL CULLUM 1:40 A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical
5. Social Security Number 6. Sex 7. / Air
er i Year | If Under 24 Hrs. | 8. Date of Birth
(Month, Day, Year) Harford Center Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) Months 1 □ M 2 □ F 93 Sept. 1916 Maryland 215-32-3032 23, Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 XNo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2301 Cullum Road 21015 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify Specify. 3 ₩Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Service Manager Public Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Winfield Mitchell Margaret Katharine Bechtold 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neil Cullum / Son 918 Luke Street, Bel Air, Maryland 21015 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Calvary U.M. Cemetery 10-13-09 4 ☐ Donation 5 ☐ Other (Specify) Churchville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final a CLOSTRIBIUM DIFFICILLIE t8 hours disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

**Physician** 014000 /Medical **Examiner** be executed attending physician and for use as the burial-tran

P.0.

Records,

Vital

Division of

Hospital or Attending

filled in by 24 hours a completely

within 2 To the

**Physician** 

/Medical

**Examiner** 

Director

Funeral

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Completed

Be ဂ

**Funeral** 

Director

show

ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the the didn't Evand to motified at

permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items

Exami Physician/Medical signed by the a Be Completed by After this certificate | funeral director, page Medical Certification: To after death.

Director: Aid in by the fu

	<u>-</u>		1 ☐ Yes 2	o 3☐ Probably 4☐ Unknown
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
25. Was case referred to medical examiner?		26. P	Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 ∰npatient 2 ☐ ER/Out	patient 3 DOA Other: 4	Nursing Home 5 Residence	6 □Other (Specify)
27. Manner of Death 1 Matural 5 ☐ Pending 2 ☐ Accident investigatio			28d. Describe how injur	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		m, street, factory, office	28f. Location (Street ar City or Town, State	nd Number or Rural Route Number,
29a Cartifier 1 Vartifying Pl	aveleign: To the heat of my knowledge	dooth accurred at the time, det	to and place and due to the constant	\

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

DUU 56296

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

Billiaum M.O.

(Check only one)

30. Name and add

29b. Signature and title of certifie

ss of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Items 25,27,28a-f per me,2896,10/08/09dhb
Reg. No.
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** September 19. 2009 8:00 Myrtle Virginia Capiletto /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City Town, or Location of Death Examiner Summit Park Health & Rehabilitation Catonsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🖫 F Days 10-02-1915 Virginia Director 213-03-6297 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show other traumatic event, the Medical Every increust be notified at Director 1 ☐ Yes 2 M No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 U.S.A. 23a 10 Holmes Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14 Bace - American Indian 11. Marital Status 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 ò If Yes, Give Year or Dates: 1 ☐ Yes 2 🕅 No Specify: ģ 3 X Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed withir Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be pe and Mental Pearl Lynch Bernard Thomasson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) De artment of Health ar Important: If item 27 is any injury or other trau Baltimore, Maryland 21228 10 Holmes Avenue Margaret SuBock - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 

Burial 2 □ Cremation 3 □ Removal from State 09-22-2009 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Parkwood Cemetery 21. Signature Funeral Service Licensee 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final DEMENTIA Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner SENILIT Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last INN APPROVED BY MEDICAL EXAMINER Due to (or as a consequence of): Examiner requires that the death certificate be executed burial-tran Due to (or as a consequence of) Box 68760. physician CERTIF Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy 5 Other (specify) signed by the a 1 Tyes 2 4No Ö 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by FRACIURE 1 Yes 2 No 3 Probably 4 Unknown OSTED ARTHMITS 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? SCHIZO AFFECTIVE Dumoin 1 □Yes 2.□No 1 ☐Yes 2 ☐No VA of Vital Attending Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XYes 2 → No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) funeral 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation <del>Natu</del>ral Accident thours after death. uneral Director: A death. 08/10/2009 Unknown M 1 ☐Yes 2 No Subject fell 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6348 Frederick Rd. atonsville, MD 3 ☐ Suicide determined 4 ☐ Homicide ö Catonsville, Assisted Living Facility 24 hours 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completely fi Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ATTENDING 200 9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 300 ARMONT PUTCE

32. Registrar's Signature

TANSINDA

31. Date filed (Month, Day, Year)

FUTE 3H BALTIMONE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day October 3, 2009 2:45 PM M James T. Carduff 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Feb 25, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Months Days Pennsylvania 1 X M 2 □ F 208-30-2701 Usual Residence of Decedent 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No MD Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1336 Perryman Road 21001 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married Specify: white If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 54-56 unk 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) mathematician 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Francis Jerome Carduff Edna Matilda Fenstermacher 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Betty Culpepper/friend 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee Ronald S. Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 2.a. Palt1. Enter the disease, or or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedials Cause (Final disease of condition resulting in death) carma Due to or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of : Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? an 24a. Was an autopsy performed? 1 ☐Yes 2 ☐ No 1 □ Yes 2 □ No 25. Was case referre examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

/Medical Examiner Ŕecords, Division of Vital Jamps within 24 hours after death.

To the Funeral Director: After this the Hospital or A thin 24 hours after

Physician/Medical 3 Completed Be Certification: To Medical

Examine

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f shov

**Funeral Director** 

þ

Completed

Be

7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Expressions is ust be netflied at

Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, the Maone.

**Physician** 

burial-trar

attending physician for use as the buria

signed by t be detach

page 2 should

filled in by the funeral director,

certificate

altimore,

Pages 1

State Registrar

DHMH 17 Rev 1/2001

29a. Certifier

(Check only one)

29b. Signature and title of certifier

(uno, MI)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

200

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Dav **Physician** October 3, 2009 1:00 A M Virginia Elizabeth Cleffi /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Wilson Health Care Center Gaithersburg Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Pear) | 9. Birthplace (State or February 14, 1924 | New Jersey 9. Birthplace (State or Foreign 5, Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 85 142-14-5636 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State show ral", or items 23a or 28a-f show Examiner must be notified at Maryland Montgomery Rockville 1 ☐Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 1515 Dunster Road 20854 United States by Funeral 14 Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 72 hours after 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No White Saltimore, Maryland 21215-0036 Specify: 3 Widowed 4 □ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) traumatic event, the Medical Elementary/Secondary (0-12) College (1-4or 5+) filed withir Hygiene. Is marked other than Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ould be Christian Ast Elizabeth Williams ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 Department of Health a Important: If item 27 Is any injury or other trau Pamela Cleffi-Rabadi/Daughter 4700 Kemper Street, Rockville, Maryland 20853 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition October 7. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Germantown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Nome/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service License M01498 RC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 15 min **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregnancy Month Day Vear 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Anemia of performe 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? (Month, Day Year) 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined filled in by 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 04115 N. Robert & Name and address of person who completed cause of death (Item 23a) (Type, Print) 20, RUSSELL AVENUE GACTHERSBURG, NO J. ROBERT BIRSCHBALH, MA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#20b, perFH, G896, 10/21/09, WS
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 200<sup>year</sup> James A. Cudney October 3:40 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Suburban Hospital Bethesda Montgomery 8. Date of Birth (Month, Day, Year) September 10,1924 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F 85 Months Days Hours Min. Illinois 343-12-3236 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Maryland | Montgomery 28a-f Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or filed within 72 hours after death with 11201 Long Pine Trail 20854 United States Funeral or items Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian, Black, White, etc. 1 ⊠Yes 2 □ No
If Yes, Give
Year or Dates: WWII 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🖾 No 2 Specify 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) International marked other than Elementary/Secondary (0-12) College (1-4or 5+) Development Program Director 5+ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental F Be 1 and 2 should be Albert James Cudney Fanny Elizabeth Van Tuyl ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a Department of Health Important: If item 27 any Injury or other the once. 27 Margaret F. Cudney/Wife 11201 Long Pine Trail, Potomac, Maryland 20854 20b. Place of Disposition (Name of campter), crematory or other place Parklawn Memorial Park 20a. Method of Disposition October 20c. Location - City or Town, State Pages 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 2009 Rockville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/ 21. Signature of Funeral Service Licensee Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 topo M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Cerebro vascular Accident /Medical Due to (or as a consequence of): Examiner Cardiac Arrhythmia Sequentially list conditions, Physician/Medical Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duri to (or se a nonesquaries of) The law requires that the death certificate be executed Sick Sinus Syndrome and burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the use as attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) pec 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 2 signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an After this certificate has page 2 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 11X7 Yes 2 □ No. 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 1 X Natural iours after death.

neral Director: A
filled in by the fu 1 🗆 Yes 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D17656 October 5, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tip Woodward, M.D. 5530 Wisconsin Avenue #550, Chevy Chase, Maryland 20815 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October MAURICE MURPHY CARROLL 5:52A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Timonium Baltimore . Social Security Number 8. Date of Birth (Month, Day, March 4 6. Sex If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** XX M 2 D F Days Hours Mary land 216-24-2373 81 Director Vrs Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location must be notified at 10d. Inside City Limits **Funeral Director** Maryland Baltimore 1 Yes 2 XXVo Cockeysville 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a 5 Oak Knoll Road 21030 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? ★ 12 Yes 2 □ No WW I I If Yes, Give 11. Marital Status 14. Race - American Indian Black, White, etc. 5 1 Never Married 2 Married Completed by within 72 hours after 21215-0036 1 ☐ Yes 2XXNo Specify: White 3XX Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Manager Real Estate Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Maurice Murphy Carroll Sr Kathryn Foster 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Mark Richard Carroll Son 1035 Saxon Hill Drive Cockeysville, Maryland 21030 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔲 Burial 2 🕅 Cremation 3 🗆 Removal from State cemetery, crematory or other place) GreenMount Crematory Oct 9, 2009 Baltimore, Maryland Donation 5 Other (Specify) nature of Funeral Solice Lice 22. Name and Address of Fadmitchell-Wiedefeld Funeral Home Inc 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph\_sician/ disease or condition **PNEUMONIA** Medical resulting in death) Due to (or as a consequence of): **Examiner** LUNG CANCER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Cause (Disease or iinjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year Pregnant at time of death Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform Yes 2 X No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ပ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending 1 X Natural 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Gertfying Nurse Practioner: To the best of my knowledge To the F death occurred at the time, date and place, and due to the co 29b. Signature and tille of 29d. Date signed (Month, Day, Year) 149 2009 s of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar JACKIE JONES,

CRNP

a.m.

2009

OCTOBER

CARROL.

MAURICE

2300 DULANEY VALLEY RD.

TIMONIUM, MD 21093

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	ulcai	Exam	mer	Teresa Marie  4a. Facility Name (if not institutio	Clarke Ch	arlebois		b. City, Town, o	r Location of	Month October 4	4, 2009 4c. County of D	
				1406 Weldon Place S	_	,		Baltimore			N,	
		uneral rector		5. Social Security Number	6. Sex 7	7. Age (In yrs. las	t birthday)	If Under 1 Year		24Hrs. 8. Date of B	rth(MM/DD/YYYY) 9 Fo	preign
	- D	rector		214-84-3451 Usual Residence of Decedent	1 M 2X F	44	Yrs.	Mortaro Day	75 110015		7, 1964	Country) Maryland
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	D 21215-0036 should be filed within 72 hours after death with the Maryland	Hygiene d other th	ပ	17. Father's Name (First, Middle,	,	•			18.Mother's	Name (First, Middle,	Maiden Surname)	<u> </u>
	212	Mental marked c event,	To Be	Linwood Anthon			19b. Mailing	Address (Stre		thy Lee No er or Rural Route Nu	oe1 mber, City or Town, S	State. Zip Code)
	MD 12 sho			Mark W. Charle	bois (hus	band)		,				aryland 21211
	ore,	of Health If item 2 her traun		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from		ace of Disposi ematory or oth	tion (Name of ce	emetery,	Date	20c. Location - Cit	y or Town, State
	Baltimore, MD	tment of F rtant: If i y or other		4 Donation 5 Other Sp	ecify:		view M	emorial	Park	10-8-09	Sykesvill	e, Maryland
	Bal	Department of H Important: If i		21. Signature of Funeral Service	Licensee		722. N	ame and Addres	is of Facility iedefe	ld Funera	l Home, Ir e. Marvlar	ig. 21.21.2
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		ned by the detached		Part II. Other significant conditi			ulting in the u	nderlying cause	given in Part	I. 23e. Did	tobacco use contribut	e to the cause of death?
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	ord:	has been a 2 should	Completed							24a. Was	psy prior	e autopsy findings available to completion of cause of
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	A Division of Vital Records, the Hospital or Attending Physician: The law require	After this funeral dir	7. T	1 Ves 2 No 27. Manner of Death	28a. Date of (Month, D		8b. Time of In		ury at Work?		how injury occurred	other. Scene
	ion	death.	Certification:	1 Natural 5 Pend 2 Accident Inves			d 6:15	am 1	Yes 2 X	₀ unk		
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)	To the	within 24 hours after death To the Funeral Director; completely filled in by the	Medical		niner:On the basis of and manner sta	examination and						
1	_	2 - 0	ž	29b. Signature and title of certifie				29c. Licens			29d. Date signed	
				Theodore	W. Kin	of JA.	m J	0.C.	M.E.	OCME	October 4, 20	
				30. Name and address of person Theodore M. King, Jr.,		of Jeath (Item 20 It Medical Ex		111 Penn St	reet, Balti	imore, MD 2120	1	
				31. Date filed (Month, Day, Year)	- A	istrar's Signature		,				
		Regist	trar	00109200	13 Consun	Jo. 17						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month DAVIS 9-22 PM BENTON 09 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Alice Manor Nursing Home N/A Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1**¥**∑1**%** 2 □ F Months Days Hours Min. Director 09/10/1936 215-42-0445 73 North Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2095 Rockrose Avenue 21211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: XNever Married 2 Married Maryland 21215-0036 1 ☐ Yes 2/2 No þ Specify. Specify 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Laborer Bethlehem Steel N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be unknown ဥ unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21202 Alisa B. Kobrinetz-quardian 22 Light St. Suite 403 Baltimore, Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State

**Physician** Medical xaminer

burial-trar nse ģ

law requires that the death certificate be executed

the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director; After this certifica

within 24 hours a

completely filled in by the

Division or Vital Records, P.O. Box 68760,

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1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Zion Cem. 10/8/09 Baltimore MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility MARCH FUNERAL HOME-EAST E. North Avenue Baltimore, MD 21202 Wane 1101 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YO Derne Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Van Due to (or as a consequence of) IF FEMALE: If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4□Pregnant at time of death 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1□ Yes 2 1 No 2 □ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Lawrsing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D31464

State Registrar N. ENTAN ST SINTE 308 BALTIMOIZE MD 21201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

473 tm1

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2009 Mary Elizabeth DeMartin October Medical 8:15A 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Balto. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 - M 2X F Davs (Month, Day, Year) Hours Country)

Maryland Director 213-30-8494 <u>February</u> Usual Residence of Deceden 10a. State 10b. County with the Marviand notified at 10c. City. Town or Location Director 10d. Inside City Limits 28a-f Md. Balto. Parkville 1 Yes 2 No 10e. Street and Number 10f. Zip Code ms 23a o 10g. Citizen of What Country? Funeral 10027 Magledt Road 21234 USA items 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Medical Examiner 14. Race - American Indian, ò Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 XNo Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 X No Specify: "natural" 3 Widowed 4 ☐ Divorced Completed White Specify: Year or Dates Decedent's Education Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (9-12) College (1-4 or 5+) the Secretary Oil Compnay traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည Daniel FIsher III Ethel Higdon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is any injury or other trau Diana Hamilton DTR. 10027 Magledt Rd. Parkville, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 □ Donation 5 X Other (Specify Entombment Gardens of Faith 10-12-2009 Balto. Md. 21. Signature of Funeral Service Licenses 22. Name and Address of FacilitySchimunek Funeral Home 9705 Belair Rd. Nottingham, Md, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Physician/ Onset and Death DEMENTIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin Cause (Disease or imjury that initiated events Due to (or as a consequence of) ng physician a resulting in death) Last Physician/Medical th certificate be Box 68760 IF FEMALE: ettendin or use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Pregnant at time of death Month Hospital or Attending Physician: The law requires that the dea signed by the Yes 2 No 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed page 2 should 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed? death? 2 X No 1 Yes 2 No in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 1 Tyes 2**X** No Other: After this 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending s after death. 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral D completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check To the 😨 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one tle of c 29b. Signature and 29d. Date signed (Month, Day, Year) 009

State Registrar

8:15

OCTOBER

DEMARTIN

of Vital

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CRNP

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 10:25 AM 2009 Oct /Medical 4a. Facility Name (If not institution, give str 4c. County of Death et and number 4b. City, Town, or Location of Death Examiner HIMOVE 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5. Social Security Number 9. Birthplace (State or Foreign vrs. last birthday **Funeral** 1 M 2 F Hours Min. 206-18-6948 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be rediffed at 1 Pres 2 No Funeral Director MD Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2306 rove St. USA كالفاله death v 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubas, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced 3altimore, Maryland 21215-0036 1 ☐ Yes 2 TNo If Yes, Give Ye ar or Dates: Specify. Completed by 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Social Security Admin Specialist ayears and Mental Hygie Is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert B. Lee Spencer ೨ Marie 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route umber, City or Town, State, Zip Code) Department of Health ar important: if item 27 is any injury or other trau once. MD 21215 Hephanie Da farter/Daughter 2508 Dakley Ballinae s Que. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State edur Hill Cemetery 10-12-2009 Baltimore, Mo 4 Donation 5 Other (Specify) 21. Signaturé of Funeral Service Licensee 22. Name and Address of acility Vauging. Greene funeral 515. augun Randallstown, ND 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hadre. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Severe encernalogath weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner weeks Due to for as a consequence of: Sequentially list conditions, if any leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner attending physician and for use as the burial-transi Suspected meningits
Due to (or as a consequence of): weeks resulting in death) Last P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 Tes 2 No 3 Probably 4 Unknown page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 1 Yes 2 No 1 ☐ Yes or Attending Physician: funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 No 1 → Apatient 2 □ ER/Outpatient 3 □ DOA this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury at Work? Certification: 28d. Describe how injury occurred After 1 Aatural 5 Pending investigation ours after death. neral Director: A filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I

completely filled 29a. Certifier fretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

State

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AT 2438946

Abdallah; Union Memorial Hospital, 201 E. University PKWY, Baltimore, MD 21218

10/2/09

WD

32. Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death nt's Name (First, Middle, Last 2 Date of Death 3. Time of Death Physician/ 05:20 M Medical 4b. City, Town, or Location of Death **Examiner** Hospice *lowson* If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Yrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** Director items 23a or 28a-f shor 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Important If fleat and Mental Hygene. Important If fleat and Mental Hygene. and "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 Yes 2 No more 10e. Street and Number 10g. Citizen of What Country? 21207 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ₩Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industr (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) nday (0-12) Be . Page 1 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) e of Funeral Service Li Signatu 23a. Part 1. Enter 1. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ CARDIOMYOPATHO 117010745 Medical resulting in death) Due to (or as a consequence of): <sup>•</sup>Examiner Sequentially list conditions, if any leading to introduct cause. Enter Underlying Physician/Medical Examiner Due to for as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ in the past 12 months?
1 Yes 2 No Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by DIABETES 1 Yes 2 □ No 3 □ Probably 4 □ Unknown CHRONIC KIDNEY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 No 1 🗌 Yes 25. Was case referred to medica 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Nother (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 2 Accident 3 Suicide 4 Homicide injury 5 Pending 1 🗌 Yes 2 \ No hours fter death Investigation within 24 hours fler deat To the Funeral Director completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

DOBETMAN. MD

Registrar

NEHARLES STI SUITE 4105

OCTOBER 6, 2004

BALTIMORE, MO 21204

		,	For State Registrar		State of M	aryland		artment of F <i>rtificate of</i>	lealth and l <i>Death</i>		IENE eg. No.	11	32331
	Physici /Medic			DWAR	_D		D	ANZ		2. Date of Deat Month	Day 20	ear b9	3. Time of Death 4. DD A, M,
	Examin Funeral Director	er	4a. Facility Name (If  NORTHWE  5. Social Security Nu  220-22-61	37 H 6. S 78	3PITAL	CENTE	ast birthday) Yrs.	4b. City, Town, o  RAVOR  If Under 1 Year  Months Days	r Location of Death ALLS TOW If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthp	place (State or Foreign
	iryland show	_	Usual Residence of I 10a. State	Decedent 10b. County		10c. City	, Town or Lo	cation				1	0d. Inside City Limits
	ne Ma 18a-f s	Director	MD	Baltimo	re	Cat	onvill	_					1 ☐ Yes 2 🛣 No
	with th	Dir	10e. Street and Num 1323 Lafa					10f. Zip Code 2120	7	1	0g. Citizen of Wha	at Cour	itry?
99	72 hours after death with the Maryland "natural", or items 23a or 28a-f show ofcal Examinari, ust be retified at	/ Funeral	11. Marital Status  1 Never Marrie		12. Was Decedent Armed Forces? 1 XYes 2				Hispanic Origin? (Stan, Mexican, Puerto	pecify Yes or No- Rican, etc.)	USA  14. Race - American Indian, Black, White, etc.  Specify: White		
Maryland 21215-0036	2 hours atural", cal Exa	ted by	3 ☐ Widowed 4	15. Decedent's Ec	Year or Dates:	WWII	16a. Decedent's Usual Occupation 16b.						
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Baltimore,	permit. Departn Importa any inju		21. Sign ure unu	eral Service Lioun	Sel Sel	Z	8   F	'uneral H	ess of Facility Ste ome of Ca ndson Ave	tonsvil1	le, Inc.		
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<u> </u>	Physicia this cert al direct	To Be	examiner?	ŀ	Hospital:	ent 2 🗆 E	R/Outpatien	t 3 DOA Oth		th <i>(Check only one</i> ome 5 ☐ Reside		(Specif	
Division of Vital Records,	ending Prath. Pr. After the funeral	ation:	27. Manner of A ath 1 Natural 2 Accident	5 ☐ Pending investigation	28a. Date of Inju (Month, Da	ry 2	28b. Time of Injury	28c. Injur Worl	y at	28d. Describe ho		(	,
Divis	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate h completely filled in by the funeral director, page	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubuilding, etc	ury - At hon c. (Specify)	ne, farm, stre	eet, factory, office		28f. Location (Sti City or Town	reet and Number , State)	o <i>r Rur</i> a	I Route Number,
	To the Hospita within 24 hours To the Funeral completely filled	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Ph	ysician: To the best niner: On the basis o and manner sta	f examinati	rledge, death on and/or inv	occurred at the tile restigation, in my co	me, date and place opinion, death occur	, and due to the carred at the time, da	ause(s) and mannate and place, and	ner as s	tated. the cause(s)
	To the within 2 To the comple	2	29b. Signature and tit	le of certifier	,	221)		29c. Licens			Od. Date signed (I		
1			30. Name and addre	of person who	completed cause of d	eath (Item	23a) (Type, F	Print)	3977 Burni	<del>\</del>			
	Stat	te_	31. Date filed (Month)	Day, Year	JU HISO	ar's Signatu	ADION	rylen	BURNI	e h	1. 2016	21	
	Registra		00	J 0 9 20	Ut ausen	a p	2. 400	we					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 💹 🖟 🗦 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** October 2009 M. Keith Dunklee 7:05 рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Prince George Patuxent River Rehabilitation Ctr. Laurel If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Y March 27 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 12X2XM 2 □ F 85 Director 192-14-4018 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Events. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 No Director MD Prince George Laurel 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20708 USA 9000 Briarcroft Lane, #123 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1x⊟Xes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 25 XMarried white þ 1 ☐ Yes 2X XVo Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Merchandizing Manager Automotive 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elanson Dunklee Gladys Bahr ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9000 Briarcroft Lane, #123, Laurel, MD 20708 Leona W. Dunklee/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Oct. 2009 1 ☐ Burial 2XX remation 3 ☐ Removal from State West Arundel Crem. Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funera Service Licensee / M00770 313 Talbott Ave., Laurel, MD 20707 23a. Part 1. Enter the dise or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. Approximate Interval Between Onset and Death shock, or heart failure. I Immediate Cause (Final disease or condition resulting in death) **Physician** months Esophageal Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause Enter Undership Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical (F FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XX MUnknown funeral director, page 2 should Completed 24a. Was an autopsy perform 24b. Were autopsy findings available prior to completion of cause of death? 2XXVo 1 □ Yes 2**X**XN0 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X ursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2**X∑N**o Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 □Yes 2 □No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifie XXcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only

Box 68760,

P.O.

Division of Vital Records.

State

Registrar

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

OCT 0 9 2009

14300 Gallant Fox Lane, #210 Jagdish Shesadri, M.D. 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

Bowie, Maryland

October 5, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 8 per in g896 10-9-09 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** October 200°9° 10:39 A.M David Brian Donovan /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford County Upper Chesapeake Medical Center Bel Air | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. | 7, 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday, 1055 **Funeral** 220-64-0141 1**X** M 2□ F 54 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County ıral", or items 23a or 28a-f shov I Examiner must be notified at 1 ☐ Yes 2 No Darlington Maryland Harford County Director 10g. Citizen of What Country? 10e. Street and Number 4005 Paddrick Road 10f. Zip Code 21034 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married & Married Specify: White 1 ☐ Yes 2 🛣 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry injury or other traumatic event, the Medical Harford Community College (1-4or 5+) N/A Elementary/Secondary (0-12) Plumber / Mechanic College 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna S. Novak Frank H. Donovan 19a. Informant's Name/Relationship (Type. Print)
Mrs. Jennifer J. Donovan (Wife) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4005 Paddrick Road, Darlington, Maryland 21034 Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Oct.7,2009 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Forest Hill, Maryland Evans Funeral Chapel 4 ☐ Donation 5 ☐ Other (Specify) Evans Funeral Chapel & Cremation Services-Bel Air 3 Newport Drive, Forest Hill, Maryland 21050 21. Signature of Funeral Service Licensee Acon X 23a. Part1. Enter the direase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart fillure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician robable myocardia /Medical Due to (or as a consequence of): Examiner herosclero if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Morbid Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by rtension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of 24a. Was an death? 1 🗌 Yes 2 □ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 □ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No To the Hospital or Attence within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. 500 Upper CheSapeak D. Bel Air MD ermin 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

09-07668 Paul Damiani

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2, Date of Death 3. Time of Death 1 Decedent's Name (First Middle Last) Physician/ Month Day October 2, 2009 1145 hrs Medical Examiner Paul Carlo Damiani 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 1050 Wintergreen Terrace Rockville Montgomery 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 24Hrs. If Under 1 Year 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Foreign Country) Months Davs Hours Min Director  $_{1}X_{M}$ November 24,1961 47 287-68-9258 Ohio Usual Residence of Decedent 10d, Inside City Limits 10b County 10c. City, Town or Location any 1 X Yes 2 No or 28a-f show items 23a or 28a-f shorist be notified at once. Rockville Maryland Montgomery hours after death with the Maryland Director 10g, Citizen of What Country 10f. Zip Code 10e Street and Number 20850 1050 Wintergreen Terrace United States Funeral 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. must be Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 1X Yes 2 9 Yes 2 X No specify: Specify Divorced Yes, Giva Year 1985-2009 White permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other fraumatic event, the Medical Examiner. ₫ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) MD 21215-0036 5+ Global Management Executive Electronics 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Luigi Gino Damiani Maureen Celeste Dautremont 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1050 Wintergreen Terrace Rockville, Maryland 20850 Stephanie J. M. Damiani/ Wife 20b. Place of Disposition (Name of cemetery, October 10, 20c. Location - City or Town, State 20a, Method of Disposition Baltimore, crematory or other place)
Capitol
Crematory Burial 2 X Cremation 3 2009 Columbus, Ohio Donation 5 Other Specify: 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20814-3501 21. Signature of Funeral Service Licensee M00335 Approximate Interval 23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line M. dical Death a. Atherosclerotic cardiovascular disease Immediate Cause (Final disease vaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed and trans. 23a,2/,permE, g896 10/20/09 TT Physician/Medical X UNPENDED AMENDED attending physician or use as the burial Box 68760. 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Day Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown icate has been signed by the page 2 should be detached for 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 No 3 Probably 4 ✔ Unknown Completed Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy performed? death? ✓ Yes 2 2 No 1 🗸 Yes certificate r this certific al director, p 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? Other, Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient ER/Outpatient 3 ٩ 1 Yes No After the 28a. Date of Injury (Month, Day, Year 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Yes 2 No Director: d in by the f Pending within 24 hours after death. Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide Funeral Di or Town, State Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the | one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E October 3, 2009

30x1 et

Registra

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

30. Name and dress of person who completed cause of death (Item 23a)

Pamela E. Southall, MD

09

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #20c Per FH G896 10/09/09 JH State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician MILTON DREXLER Month OC T D Day 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL HOWARD COLUMBIA | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | 04-03-1914 5. Social Security Number 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Funeral 111-32-1952 Director NY Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Experience must be notified at Director 1 ☐ Yes 2 🛛 No MD HOWARD COLUMBIA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10101 GOVERNOR WARFIELD PKWY, #346 21044 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 X No ⋧ Specify: 3 Widowed 4 Divorced Specify: WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the 3% gones. Elementary/Secondary (0-12) College (1-4or 5+) PHYSICIAN MEDICAL 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname, SAMUEL DREXLER LEVITT ဂ ANNE 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MOLLIE DREXLER/WIFE 10101 GOVERNOR WARFIELD PKWY, #346, COLUMBIA, MD 21044 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🕅 Burial 2 □ Cremation 3 🖾 Removal from State 4 □ Donation 5 □ Other (Specify) FT. Meyer ARLINGTON\_NATIONAL ARLINGTON. 10-08-2009 22. Name and Address of Facility SOL LEVINSON & BROTHERS, INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** uplogenu disease or condition resulting in death) /Medical Due to (or as prope purice of): Examiner Slage Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine as a consequence of): The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d Date of delivery for 3 Ectopic pregnancy in the past 12 months? 4 ☐ Pregnant at time of death Month Day Year 5 ☐ Other (specify) signed by the a ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? Yes 2 No 2 □ No 1 □Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 \sum Nursing Home ို 1 ☐ Yes 2 1 No 1 Thpatient 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death within 24 hours after death.

To the Funeral Director: After completely filled in by the funera Certification: 28b. Time of 28d. Describe how injury occurred Hospital or Attending 1 Natural 5 Pending 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) BM 8885723 Virethyphanlas MD DCT 4, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Viresh Mohanlal Howard General County 31. Date filed (Month, Day, Year) 32. Registrar's Signatur State OCT 0 9 2009

DHMH 17 Rev 1/2001

Registrar

09-07693 Jay A. Early

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

iy A. ⊏any		State of Maryland / Departification State	ent of Health and Mental H		-				
Physician/ ledical Examiner		Registrar  1. Decedent's Name (First, Middle,Last)	ate of Death	Reg. No. 2. Date of Death	ku U	3. Time of Death			
		JAY A. EARLY		Month Day October 3, 200	Year 9	1844 hrs			
		4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of Death		c. County of Deat	h			
		Johns Hopkins Hospital	Baltimore		N/A				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	hday) If Under 1 Year If Under 24Hrs	8. Date of Birth (MM		rthplace (State or Foreign			
Director		220-80-0942 1XXM 2 F 48	Yrs. Months Days Hours Min	04/03/196		ountry) ARYLAND			
		Usual Residence of Decedent		104/03/196	71 111	ANTIAND			
any		10a. State 10b. County 10c. City, Town	or Location			10d. Inside City Limits			
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Maryland 28a-f show 1 at once.	cto	10e. Street and Number	10f. Zip Code	10g. Cit	tizen of What Cou	untry?			
or 22	Director	1100 E CHASE STREET	21202		U.S.A.				
vith t s 23a e not		11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin? (S	pecify Yes or No-	14. Race - Ame	rican Indian, Black,			
eath y	Funeral	1 X Never Married 2 Married Armed Forces?	If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.				
fter d		3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 XX No specify:		Specify: BL	ACK			
ours a atura tamir	d by	15. Decedent's Education (Specify only highest grade completed) 16a.	Decedent's Usual Occupation (Give kind of during most of working life, DO NDT use ret		Kind of Business	/Industry			
72 hc	eted	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. BO ND 1 use fet	ined)					
5-0036 iled within 72 Hygiene. I other than the Medical	Comple	9th grade	LABORER		N/A	<u></u> .			
5-0 iled v Hygi		17. Father's Name (First, Middle, Last)		e (First, Middle, Maide	n Surname)				
2121: vuld be fil Mental I marked ic event,	Be	ROBERT WARD	ROSE M.		Oite as Tarres Char	- 7:- Codo\			
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by MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland feath and Mental Hygiene. Item 27 is and offer all maturally, or items 23a or 28a-f she tranmatic event, the Medical Examiner must be notified at once		Rose Early/ Mother  20a. Method of Disposition  20b. Place of Disposition	1100 E. Chase Stree	Date 200	ore, Mar Location - City o	yland 21202 or Town, State			
MOre Pages 1 a nent of He ant: If its			tory or other place)		Í				
Page ment tant:		4 Donation 5 Other opening	11-2			, MARYLAND			
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygene. Important: If item 27 is marked other the injury or other traumatic event, the Med		21. Signature of Funeral Service Licensee	22. Name and Address of Facility T I WILLIAM C BROWN CO	MMUNITY FU	JNERAL H	OME P.A East			
		23a Part I Enter the disease of complications that caused the death Do n	of enter the mode of dying, such as cardiac	or respiratory arrest. s	nock, or hear	Approximate Interval			
Physician /Medical		23a. Part I. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat failure. List only one cause on each line.  Immediate Cause (Final disease a. Narcotic (heroin) and ethanol intoxication							
xaminer	0.	Immediate Cause (Final disease or condition resulting in death)  a.NAICOLIC (TIETOIT)  Due to (or as a consequence of):	) and ethanol intoxi	Cation					
		Sequentially list conditions, b							
	ner	if any, leading to immediate Due to (or as a consequence of):							
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Sox 68760, death certificate be exert e attending physician a for use as the burial -	Me	IF FEMALE: 23c. If yes, outcome of pregnancy	, gost ill of	2	3d. Date of delive	ery			
687 ertific ding e as t	Physician/	23b. Was decedent pregnant in the past 12 months?	nancy	Day Year					
OX 68 eath certif	sic	1 Yes 2 No 9 Unknown 9 Unknown	5 Other (Specify)						
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SOF law ra has b	출			autopsy performed	? death?				
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Division of Vital Records, P.O, Box 68760,  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	one) 2 Medical Examiner:On the basis of examination and/or	investigation, in my opinion, death occurred	at the time, date and	place, and due to	the cause(s)			
To wit	₩ Wec	and manner stated.  29b. Signature and title of certifier	29c, License number		d. Date signed (A				
		Language March	O.C.M.E.	0	ctober 4, 200	9			
		30. Name and address of person who completed cause of death (Item 23a)							
		Margarita Korell MD. Assistant Medical Examiner	111 Penn Street, Baltimore, MD	21201					
	tate	11111 11 11 11 12 12 12 12 12 12 12 12 1	add						
Regi	strai	UCIUS EURO CERUNO B. ASE	NAME OF THE PERSON OF THE PERS						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month DEINE /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMOR If Under 1 Year | If Unde 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 24 Hrs. Date of Birth (Month, Day, **Funeral** Min. Days 1 ☐ M 2 🕏 F Months Hours 117-14-8202 86 Director 23 <u>Jan</u> 1923 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show the Madical Exp. nir or must be notified at 10d. Inside City Limits Director MD Carrol1 **Eldersburg** 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6126 Ash Grove Court 21784 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2 ☐ No Specify 3 ☑ Widowed 4 ☐ Divorced Specify: white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) domestic permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 is marked other th any Injury or other traumatic event, the once. 12 homemaker 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) John Lefko Anna Sekerak ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline M. White (daughter) 6126 Ash Grove Ct., Eldersburg, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 Trother (Specifyentombment Crest Lawn Memorial 10-8-09 Marriottsville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee ▶ Page Hargert Sterbert P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events to (or as a consequence of) The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, and burial-trar resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year signed by the a d be detached for 5 ☐ Other (specify) 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ page 2 should 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy performed? Yes 20 No certificate 1 ☐ Yes 1 ☐ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner: 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 npatient ٩ After this 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury Certification: 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 5 Pending investigation 1 Natural 2 Accident 1 TYes 2 No 3 ☐ Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001

		1	1 - State Registrar	State of Ma	ryland / Dep <i>Ce</i>	artment of F rtificate of I			ene g. No. 2	9 32388	
	Physici	an	1. Decedent's Name (First, Middle, La					2. Date of Death Month	Day Year	3. Time of Death	
/Medical			DAVID EDWAR  4a. Facility Name (If not institution, gir	4b. City, Town, or Location of Death			ER 6, 2009 6:55 P				
الممان	Examir	ier	2700 Old Jop			Joppa	Location of Boats		Harford		
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	9. Bi	rthplace (State or Foreign country)	
	Director		218-07 <b>-</b> 4295	1 ☑ M 2□ F	92 Yrs.	WORKIS Days	TIOUIS IVIII.	Jan. 17,		ryland	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation		-		10d. Inside City Limits	
	Mary Ind	ţċ	Maryland Harford		Joppa					1 ☐ Yes 2 📉 No	
	or 28g	Director	10e. Street and Number		υορρα	10f. Zip Code		10	g. Citizen of What C	ountry?	
	23a ust b		2700 Old Joppa	Road		21085		1	USA		
	er dez	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp .n, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi		
36	rs aft	by	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:		1 □Yes 2 No	Specify:		Specify:	White	
9-0	be filed within 72 hours after death with the Maryland that Hygiene.  so other than "natural", or items 23a or 28a-f show event, if a fivelical Exa "if ar must be rodified at	Completed	15. Decedent's E (Specify only highest gr		16a. Dece	dent's Usual Occup	ation	. 1	6b. Kind of Business		
21215-0036	within 7 ene. <b>than "r</b>	nple	Elementary/Secondary (0-12)	College (1-4or 5+	) (Give	kind of work done of DO NOT use retired	luring most of work  )	ing			
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ary	2 should be f h and Mental I ' is marked of raumatic eve	욘	19a. Informant's Name/Relationship	(Type. Print)	19b. Maili	ng Address (Street a			City or Town, State,	Zip Code)	
	1 and 2 Health a tem 27 is		Dale Emge / Son		I				ryland 21		
ore	SEE		20a. Method of Disposition 1  ☐ Burial 2 ☐ Cremation 3 ☐	Domound from State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plac	e)	Date 2	0c. Location - City or	r Town, State	
ij	Pages tment of I tant: If ite		4 Donation 5 Other (Speci		Bel Air	Memorial	Gdn 10-1	0-09 Be	el Air. Ma	arvland	
Baltimore,	permit. Page Department of Important: If any injury or once.			mar I	Mc	2. Name and Addres CCOMAS Fui 317 Cokest	ss of Facility neral Hom nury Road	e, P.A.	on Maryl:	•	
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	injunations that caused to	he death. Do not en	ter the mode of dyin	g, such as cardiac	or respiratory arres	st,	Approximate Interval Between	
4	Physician	ì	Immediate Cause (Final disease or condition	CAD						Onset and Death	
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):							
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b Due to (or as a	as a consequence of):						
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68760,	tificate be executed g physician and as the burial-transit	d									
	÷ So e	/Mec	IF FEMALE:	23c. If yes, outcome o	fnregnancy	7.70					
Вох	law requires that the death cert as been signed by the attending 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2	Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify)	1		23d. Date of de Month	elivery Day Year	
Ö.	that the de ned by the a detached f	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 🗌 Unknown							
S, D.	ss that gned		Part II. Other significant conditions	contributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute t	to the cause of death?	
ord	w requires t s been signe should be o	Completed by	COPD					1 ☐ Yes	3	Probably 4 Unknown	
ec	e law r has be je 2 sh	nple	hyponationia					24a. Was an autopsy		utopsy findings available completion of cause of	
	Th ate pag							performe 1 ☐ Yes 2	ed? death? ■No 1 □ Ye	s 2 No	
<u> </u>	Physician: r this certific ral director, I	Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:		Othe		h (Check only one)			
of	a Phy er this	n: To	27. Manner of Death	28a. Date of Injury	t 2 ER/Outpatie	IL 3 LI DOA	4 LI Nursing Ho	ome 5 Resident 28d. Describe how	nce 6 Other (Spenior occurred)	ecify)	
ion	nding ath. r: Afte re fun	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	<i>(Month, Day</i> , n	Year) Injury		? Yes 2 □ No		,,		
Vis	r Atte er der recto by th	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of Injur-	y - At home, farm, str (Specify)	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or F	Rural Route Number,	
	ital o										
	To the Hospital or Attending Physician: within 24 hours after deals. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Example 1	hysician: To the best of miner: On the basis of a and manner state	examination and/or ir	h occurred at the tin vestigation, in my o	ne, date and place, pinion, death occur	and due to the car red at the time, dat	use(s) and manner a te and place, and du	as stated. e to the cause(s)	
	Vithi Comp	M	29b. Signature and title of certifier			29c. License	number	29	d. Date signed (Mon	th, Day, Year)	
			Wend Kl	-	D 3/295						
			30. Name and address of person who	completed cause of dea	ath (Item 23a) (Type,	Print)		2 . 4	nd 2120	26	
	- Ct		31. Date filed (Month, Day, Year)	2 WD	ath (Item 23a) (Type,	Lowwit	proc 1	Bout n	nd 2120	9	
ı	Sta Registra		nr n 9 200	2 Printer	A. Am	Kad					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2:30F Physician Month Day 2009 Barbara V. Forsyth /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square Rosedale Age (In yrs. last birthday, If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 X F Director 213-36-5964 October 8,1937 Maryland Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or Items 23a or 28a-f shov Examiner must be notified at Md. Balto. Rosedale 1 ☐ Yes 2X No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8423 Avery Road 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Ite Yes 2X No 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify White 2 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Rate Clerk Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph M. Aversa Vittoria Procopio ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 8423 Avery Road Rosedale, Md. 21237 James Forsyth altimoré, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-10-2009 Most Holy Redeemer Balto. ,Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** lara e intestine ISCh emic resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Little onderlying Cause (Disease or injury Due to (or as a consequence of): Examiner that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 physician Physician/Medical the as attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 □ Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed certificate 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specity) Hospital: 1 Yes 2 No 1 Inpatient 2 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. the

State Registrar 29b. Signature and title of certifier

HO 31. Date filed (Month, Day, Year)

Anne

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Anne Ho

9000 Franklin Square

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month. Dav. Year)

Drive, Baltimore, Maryland 21237

-7-2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 20200 Date of Death
 Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** 12:15 AM 2009 OCTOBER 6, JACK FINE /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Harford Nichols Senior Care Edgewood If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1**☑** M 2□ F Hours Director Pennsylvania 95 1914 July 4, 190**-**05**-**1257 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Director Maryland Harford Belcamp 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21017 USA 4325 Gilmer Court Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: White Specify ģ 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VA Hospital Dental Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rebecca (nmn) Snyder David (nmn) Fine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4325 Gilmer Ct., Belcamp, MD 21017 Michele Davenport / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 □ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Shaare Torah Cemetery 10-8-09 Pittsburgh, PA 21. Signatur A Funeral Service Licens Mame and Address of Facility
MCComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an 25. Was case referred to medical examiner? Nichol Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Styler (Specify) Senior Car 2 No 1 🗆 Yes 2 ER/Outpatient 3 DOA Certification: To 1 🗌 Inpatient 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Natural

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760,

with the Maryland

Maryland

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attending physician as the page 2 should this certificate or Attending Physician: after death. n 24 hours af within 24

2 Accident

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

29b. Signature and title of confifier

State Registrar

DHMH 17 Rev 1/2001

Medical

imorgan Mr

6 Could not be

39. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature

and manner stated.

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

**ORIGINAL** 

1 ☐ Yes 2 ☐ No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month/Day, Year)

		•	For State of Marylands State of		artment of Heal tificate of Dea			100	110	22201	
Physician/			1. Decedent's Name (First, Middle, Last)		2. Date of Deat	Month Day Year					
Medical		al	Gladys Elizabeth Francis  4a. Facility Name (if not institution, give street and number)		October			4:12 A.M			
Examiner			Gilchrist Hospice	4b. City, Town, or Location of Death TOWSON			4c. County of Death Baltimore County				
	Funeral Director	Director 216-30-0161 1 1 M 2 M F 77 Yrs				If Under 1 Year If Under 24 Hrs. 8. Date of Bi Months Days Hours Min. (Month, D March					
	and show lat	or	Usual Residence of Decedent           10a. State         10b. County         10c.	City, Town or Loc	ation				1	0d. Inside City Limits	
	Maryla 28a-f : otified	Funeral Director	Maryland Baltimore County   1	Baltimore	2					1 🗆 Yes 2 🖺 No	
	th the	al D	10e. Street and Number		10f. Zip Code	024		10g. Citizen of Wh			
	ath wi ems 2 r mus	unei	9517 Ridgely Ave.  11. Marital Status  12. Was Decedent Ever in	U.S. 13. V		234	cify Yes or No-	United 14. Race			
Maryland 21215-0036	offied within 72 hours after death with the Maryland Hygiene. All Hygiene. All Hygiene. All than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Completed by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced  Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates.		Vas Decedent of Hispani Yes, specify Cuban, Me  Yes 2 No Spe		Rican, etc.)		White,		
15-(	72 hou n "nat ledica	nple	15. Decedent's Education (Specify only highest grade completed)	(Give k	ent's Usual Occupation ind of work done during	most of workin	g	16b. Kind of Bus	ness Ind	dustry	
212	within giene. er thau the N	Con	Elementary/Seconday (0-12) $N/A$ College (1-4 or 5+)	iire. DC	fe. DO NOT use retired) Home Maker				Own Home		
nd	filed tal Hyged of the event,	To Be	17. Father's Name (First, Middle, Last)		18. 1	Mother's Name	(First, Middle, M	faiden Surname)			
<u>Z</u>	should be and Menta is marked raumatic e		Clarence Leo Jones  19a. Informant's Name/Relationship (Type, Print)			ra E. D					
	0 + C +		Mrs. Mary D. Brandt (Daughter		g Address (Street and Ni Simms Ave.	Balti	more,Ma	,		234	
Baltımore,			20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State	b. Place of Dispos	sition (Name of latory or other place)	Oct. 2009	ate 13	20c. Location - C	ity or To	wn, State	
Ĕ	t. Page 1 tment of tant: If it ijury or o		4 ☐ Donation 5 ☐ Other (Specify)	arkwood (	Cemetery	2009	)13,	Parkvil.	-		
Bai	permit. Page Department of Important: If any injury or once.	(e. )	21. Signature of Funeral Service Licenses Fair Gain	2 33	Name and Address of F eaceful Alt 2325 York R	ernativ oad T	es Fune Limonium	eral&Cre n, Maryla	nati and	on Ctr.,P.A 21093	
			23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate								
ا ژ	Physician/ Medical		Immediate Cause (Final disease or condition resulting in death)  a.     Non-small Cell lung Cause   Months   Months								
	Examiner	_	Sequentially list conditions, b.								
-	p tt	nine	if any leading to immediate cause. Enter Underlying								
g.	kecute n and al-trans	Exar	Cause (Disease or linjury that initiated events c. resulting in death) Last Due to (or as a consequence of):								
2 -	e be e) ysiciar e buria	edical Examiner	d				_				
09/89	ng phy as th		IF FEMALE:			_					
BOX 6	To the hospital or Attending Prysician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/N	23b. Was decedent pregnant in the past 12 months?  1 ☐ Yes 2 W No 9 ☐ Unknown  23c. If yes, outcome of pregnant in the past 12 months?  4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date Mont		ery Day Year	
S, P.O	ures that the signed by the detail	<u>ا ۾</u>	236. Did lobacco use contribute to the cause of de								
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<u>.</u>	sician: certifii rector,	Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 postient 2	_	Other	Death (Check				10-0-3	
o -	g Physer this er this eral di	e: To	27. Manner of Death 28a. Date of injury	ER/Outpatient 28b. Time of	28c. Injury at			nce 6 Other own injury occurred	Specify)	hospice	
0	eath. or: Afte he fun	ficat	1 Natural 5 Pending (Month, Day, Year) 2 Accident Investigation	) injury	M 1 ☐ Yes	2 🗆 No	25d. Bessing New Injury coolined				
Division of vital Records,	or Att after d Direct I in by t	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At building, etc. (Spe		et, factory, office	2	8f. Location (Str City or Town	on (Street and Number or Rural Route Number, Town, State)			
ָ ב	lospita Fhours uneral ed fillec	edical	29a. Certifier Check 2 Medical Examiner: On the basis of examina	owledge, death or	ccured at the time, date	and place, and	due to the caus	se(s) and manner	as state	d.	
	thin 24	Σ	only one)  3 Certifying Nurse Practioner: To the best of 29b. Signapore and title of certifier		eath occurred at the time,	date and place	, and due to the	cause(s) and mann	er as sta	ited.	
	⊼ <u>≱                                   </u>		29b. Signature and title of certifier  29c. License number  29d. Date signed (M						vionth, E	2009	
	3	ŀ	30. Name and address of person who completed cause of death (II	tem 23a) (Type, Pr	rint)	,,,,				/	
	od.		AARON J CAARUFES MD G	701 NG	CHARLES	ST	Tons	m m	2		
	Stat Registra	_	31. Date filed (Month,-Day, Year)  OCT 0 9 2009  32. Figistrar's Sig	nature .	arkel						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #18 Per ANA BD (C896 I and /1/2/09 TH) to Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 3:43PM 2009 Medical Examiner 4a. Facility Name (if not institution, give street and number) 4c. County of Death Town, or Location of Death BAUTIMORE WASHINGTON BURNIE 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 9. Birthplace (State or Foreign Country)
Maryland 7 Age (In vrs. last hirthday) **Funeral** 1 □ M 2 TF Hours Min. Director 216-18-4444 Usual Residence of Decedent "natural", or items 23a or 28a-f show dical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🛣 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7355 Furnance Branch Road 21061 USA death v 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 1 Never Married 2 Married 1 Yes 2 No Completed by Baltimore, Maryland 21215-0036 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: white Specify: Year or Dates. the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Meagnes. Elementary/Seconday (0-12) College (1-4 or 5+) Bendix Corp assembly person Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Anthony Wisnewski Lottie Wystok 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Andrew Fox/son 1405 Locust Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 

Burial 2 

Cremation 3 

Removal from State 4 □ Donation 5 N Other (Specify) in state Ron 11 State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a Part 1 Approximate or heart failure. List only one cause on each line. Interval Between Immediate cause (Final PEMENTIA Physician, disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence oi) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events and the burial-tran Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No sate has been signed by the atte page 2 should be detached for Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 132St 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has perform 1 Yes 2 No Yes 2 No completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 5 Pendina 2 Accident s after death. Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, dearn occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practionery to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2009 D000 25 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year, State

Registrar

OCT 0 9 **ZUU**Y

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October **Physician** 200<sup>Year</sup> Bessie Ada Gassaway 9:14a /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Carroll Hospital Center Westminster If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Year Days Hours 1 □ M 2 □ VF 213-46-2523 Director Aug 23 1932 Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show d other than "natural", or items 23a or 28a-f shovevent, its Medical Examiner must be notified at Sykesville 1 ☐ Yes 2 🛣 No Carrol1 Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21784 551 Schoolhouse Road 2 should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or items 23s by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) domestic homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be intentional perior of Health and Mental Ada Snowden Louis Savoy ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Hurai House Ivainber, On, 6, 1907), Balto., MD 7924 Dunhill Village Circle, Apt 103, Balto., MD 21244 permit. Pages 1 and 2 s
Department of Health ar
Important; If Item 27 is
any Injury or other trau James E. Gassaway (spouse) 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State White Rock UMC Cem. 10-9-09 Sykesville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licenses Parge Hargher 3 P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 687602 attending physician for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: Atter this certifica funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) Certification: 27. Manner of Death 28h Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident the 3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one)

Registrar DHMH 17 Rev 1/2001

State

29b. Signature and little of certifier

31. Date filed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

29c. License number

		amend  For State	State of Ma	aryland / Depa			lental Hy	giene	2510	00001	
		Registrar		Cei	rtificate of	Death		Reg. No.	1117	3239	
Physic		1. Decedent's Name <i>(First, Middle, L</i> as Mary Pea		oher			2. Date of Dea Month Octobe	oth Day	00 <sup>Year</sup>	3. Time of Death 12:05am M	
/Med		4a. Facility Name (If not institution, give		61101	4h City Town o	or Location of Doath	000000				
Exami	ner	Carroll Hospice Dove House			4b. City, Town, or Location of Death  Westminster			4c. Coun	4c. County of Death  Carroll		
Funeral		5. Social Security Number 6. Se		e (In yrs. last birthday)	If Under 1 Year		8. Date of Birt	h		hplace (State or Foreign	
Director			□ M 2 X F 8		Months Days	Hours Min.	8. Date of Birt (Month, Day May 2,	1925	Coi	NY	
land ow		10a. State 10b. County		10c. City, Town or Lo	cation					10d. Inside City Limits	
Mary f sh	Ď	MD Carrol	Carroll New Windsor							1 ☐ Yes 2 ☐ No	
the 28a	Director	10e. Street and Number	10f. Zip Code				10g. Citizen o	f What Cou	Λ		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Experience and Laborates and Department of the Maryland Page.	ò	3 Widowed 4 □ Divorced	If Yes, Give Year or Dates:		I∐Yes 2∏XNo	Specify:		Spec	ify: W	Nhite	
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uld b Ment Ment Ment arked	2	Ralph Leo Ga	ıllagher			LaMo	oine Rya	lyan			
and and summer	ľ	19a. Informant's Name/Relationalis K				and Number or Run					
and 2 salth 27 i		Mr. Kevin <del>Gallagha</del>	<del>er</del> (Co-exe	cutor) 2824	4 Graybil	ll Court N	Wew Wind	sor, M	D 217	'76	
of He		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)  20c. Location - City or Town cemetery, crematory or other place)							Fown, State		
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/Medical		disease or condition resulting in death)	a. Due to (or as:	a consequence of):	1	LUN	0 (1)	Jan	-	PARACIA	
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eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d, D	ate of deli	iverv	
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Physician; The la r this certificate ha ral director, page 2	Be	25. Was case referred to medical examiner?	Hospital:		t 3 DOA Oth	26. Place of Death					
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or A after Direct in by	Certification: T	4 ☐ Homicide determined	uilding, etc	ry - At home, farm, stre . (Specify)	et, lactory, office		28f. Location (S City or Tow	treet and Nun n, State)	nber or Ru	ral Route Number,	
pital		29a. Certifier Certifying Phy	reinian. To the heat	of my knowledge death	occurred at the th	mo deto end ilini	and due to the				
o the Hospital or Attendir ithin 24 hours after death. o the Funeral Director: All ompletely filled in by the ful	Medical	(Check only one)	iner: On the basis of and manner sta	of my knowledge, death examination and/or invited	estigation, in my o	ppinion, death occur	and due to the ored at the time, or	cause(s) and i date and place	nanner as , and due	to the cause(s)	
o the lathin 2 or the loomble!	Mec	29b. Signature and title of certifier	and manner sta		29c. Licens	enumber	1	29d Date sign	de (Moden	Day Year)	

<sup>\*</sup>Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Gardner 5:184 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c-Gounty of Death 10U If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 💌 Hours Director Usual Residence of Decedent Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits death with the Maryland **Funeral Director** 1 Yes 2 No 10g. Citizen of What Country? 5392 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Newer Married 2 Married 1 ☐ Yes If Yes, Give 2 No should be filed within 72 hours after 1 ☐ Yes 2 ☑ No Specify 3 ₩idowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be ther's Name (First, Middle, Maider ည stin 19al Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number of lumbia MD 2104 Page 1 and 2 )dn Baltimore, 20a. Method of Disposition Place of Disposition (Name of demetery, crematory or other) 20b 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) . Si natur of Funeral Service Licensee 22. Name and Address of Fa 23a. Part 1. Enter the disease, or completations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Schemic disease or condition resulting in death) 1000 Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examine Date to Corns a consecuence of cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and d be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical that the death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Ectopic pregnancy Dav Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ □ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires 1 Yes 2 No Records, 3 ☐ Probably 4 ☐ Unknown completed filled in by the funeral director, page 2 should been 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 IDOA After this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29d. Date signed (Month, Day, Year) 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N CHALLES ST 6701 CHAR EX

DHMH 17 Rev 7/2009

State Registrar 31, Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 3:30 PM GERCHALK EMILY 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALMMEC ATKENS PARKUILLE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2√2 F 89 Yrs. 216-05-6478 Director July 30, 1920 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Department of Health and Mental Hygiene. Important: yor Items 23a or 28a-f show any Injury or other traumatic event, Important Examinant examinant or other traumatic event, Important examinant e **Funeral Director** Baltimore 1 ☐ Yes 2 No Parkville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7903 Aiken Avenue 21234 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Maryland 21215-0036 Be Completed by 1 ☐ Yes 2 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Banking Teller 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Elizabeth Specten John Hoffman ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mike Gerchalk/ Son 7903 Aiken Avenue, Parkville, MD 21234 Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10/07/09 Parkville, Maryland Parkwood Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Evans Funeral Chapel & Cremation Services Evans Funeral Chapel & Cren
8800 Harford Rd. Parkville,
Shock, or heart failure. List only one cause on each line.
ediate Cause Final

Secretary areas,
Secreta 8800 Harford Rd. Parkville, MD 21234 Approximate Interval Between Onset and Death **Physician** DEMENTIA years ease or condition sulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): and Due to (or as a consequence of): led by the attending physician detached for use as the buria by Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 🗀 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? FARKINSCUS 1 ☐ Yes 2 ☑ No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an HYPOTAYKOIO has autopsy performe 2 200 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) som's residence Other: 4 Nursing Home 5 Residence 6 Mother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, P.0. Division of Vital Records,

after death Director: filled in by within 24 hours a To the Funeral C completely

State

Klassz Wendy 31. Date filed (Nonth, Day, Year) Registrar

29a. Certifier

(Check only

29b. Signature and title of certifier

5 701 Kenwood 32. Egistrar's Signature

30. Name and address or person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D 31295

Baltmore

29d. Date signed (Month, Day, Year)

21206

10/6/0

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 10 06 2009 01:50 ам Ulderico Gargano Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Baltimore 7924 Bank Street If Under 1 Year If Under 24 Hrs. Social Security Numbe 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Italy) 213-28-6114 86 07/04/1923 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show idical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21224 7924 Bank Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 Yes 2 X No Specify. Specify: 3 Widowed 4 Divorced White Year or Dates ed other than "natur event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction nd Mental Hygiene marked other th 12 Foreman t. Page 1 and 2 should be filed without of Health and Mental Hygintrant: If item 27 is marked other hjury or other traumatic event, t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Bonavelacola Gargano Angela 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5103 Canyon Avenue, Baltimore, MD 21206 Rico Gargano, Son Baltimore, Important: If iten any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 10/10/2009 Baltimore, Maryland 4 Donation 5 X Other (Specify) Entombrent Oak Lawn Cemetery 22. Name and Address of Facility Leonard J. Ruck, Inc. 21. Signature of Funeral Service Licenses 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. ATHEROSCLEROTIC HE ART disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner PIABETE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of) CAD To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No signed by the a 9 Unknown g | Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by SKENOSIS 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown page 2 should Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed? Yes 2 No 1 Yes 2 No 1 🗌 Yes funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 X No 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation the Director: Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, upleted filled in by determined City or Town, State 24 hours Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's S

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31. Date filed (Month, Day,

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PARSHALL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** the Hall ٥S 200 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TOWY 24 Hrs. Age (In yrs. last birthday) 5. Social Security Number Funeral Hours 1 □ M 2 🖼 F Months Days 217-66-5118 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City\_Limits 10b. County 10a. State show th and Menial Hygiene. 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examinar must be notified at 1 Ves 2 □ No **Funeral Director** Himore ML 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with USA 21202 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Nover Married 2 ☐ Married 1 ☐Yes 2 No Specify: Black Specify: Completed by 3 ₩Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (9-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be INNIC -orenzu 2 19a. Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 I Platinum vschton aughter 1380 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stat 20a. Method of Disposition permit. Pages 1
Department of H
Important: If itel
any Injury or ott 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) US 22. Name and Address of Fvauch n 21. Signature of Funeral Service Licensee Ba Himore Mational 23a. Part 1. Entertible disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ough UND Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, ir any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to lot as a consequence on. attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 □Yes 2 No Day Year 4 Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown this certificate has been sail director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2/100 2 No 1 □ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Hospital: Other: 4 \( \sum \) Nursing Home 2 ER/Outpatient 3 DOA 1 Inpatient 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural
Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

l or Attending Physician: The law requires that the death certificate be executed after death. within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Hospital

State Registrar

Medical

540 01

29a. Certifier

(Check only one)

29b. Signature and title of certifie

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 VR 32. Registra

and manner stated

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1)00 5

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

💢 🗬 rtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, 0

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			1- Registrar  For Amend Item 23 State of Maryland, Dep 1- Registrar  Co	artment of Health and Me ertificate of Death		ene .No. 2009 - 82399
			Decedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
	Physicia /Medic		Doris R. Hamilton		Septemb	Day 26, 2009 22:58 PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
			Franklin Square Hospital Center	Rosedale		Baltimore
H	Funeral Director		5. Social Security Number 2 6. Sex 7. Age (In yrs. last birthda) 1 M XXF 87 Yrs.	/) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min. IN	8. Date of Birth  (Month, Bay,  V • 1 9 ,	9. Birthplace (State or Foreign Maryland
	pu v		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	ocation		10d. Inside City Limits
	shov	'n		imore		1 ☐ Yes 2 🛣 No
	the M 28a-f potifie	Director	10e. Street and Number	10f. Zip Code	100	, Citizen of What Country?
	3a or		622 N. Stuart Street	21 221		USA
36	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show marked other than "notice! Examiner must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married  3 XWidowed 4 Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates;	Was Decedent of Hispanic Origin? (Specify Yes, specify Cuban, Mexican, Puerto Find The State of	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc.  Specify: White
15-00	n 72 hou ''natura	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Dec	edent's Usual Occupation to kind of work done during most of working DO NOT use retired)	g   16	bb. Kind of Business/Industry
12	withi jene. thar	E O	Elementary/Secondary (0-12) College (1-4or 5+)	omemaker		Own Home
ğ	filed wi Hygier other th	Be C	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Ma	
<u>la</u> n	should be fand Mental s marked o	To B	William Starkey	Magdali	ne Scha	ndl
Mary	nd 2 shou alth and M 27 is ma r trauma		19a. Informant's Name/Relationship (Type. Print) Sandra Petty/ Daughter 622	ling Address (Street and Number or Rural N. Stuart St. B	Route Number, C altimor	City or Town, State, Zip Code)
altimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any injury or other traumatic enone.		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  4 ☐ Donation 5 ☐ Other (Specify)	position (Name of ematory or other place) wn Cemetery 09/3		c. Location - City or Town, State Baltimore, MD
Baltii	permit. F Departm Importar any injur		21. Signature of Juneral Service Licensee	22. Name and Address of Facility 300 onnelly Funeral		
			23a Part 1 Enter the disease or complications that caused the death. Do not a	nter the mode of dying, such as cardiac or		
4	Physician /Medical	i i	shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	olus	diogen	Interval Between Onset and Death
	Examiner		Deep Vein Thr	combosis		i
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			
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Ö,	icate be executed physician and s the burial-transit		resulting in death) Last Due to (or as a consequence of):			
8760	cate b	dical	d			
D. Box 6	ath certif ttending or use as	Physician/Me		☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
P.0	uires that the de signed by the a d be detached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
Records,	w requires been sign should be	ted by			1 ☐ Yes	2 No 3 Probably 4 Unknown
l Rec	sician: The law i certificate has b irector, page 2 sh	Completed			24a. Was an autopsy performe 1 □ Yes 2	24b. Were autopsy findings available prior to completion of cause of death?  ↑No 1 □ Yes 2 □ No
Viital	cian: ertific ector,	Be (	25. Was case referred to medical examiner?	26. Place of Death	(Check only one)	
1	Physic this c	၉	1 Ves 2 No Hospital: 1 Inpatient 2 ER/Outpati			ce 6 Other (Specify)
Division of	or Attending Physician: after death. Director: After this certific. in by the funeral director, I	ation:	27. Manner of Death  1 Natural 5 Pending (Month, Day, Year)  2 Accident Injury  28a. Date of Injury (Month, Day, Year)		8d. Describe how	injury occurred
Divis	al or Atte s after de al Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office 2	8f. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital or Attend within 24 hours after death. To the Funeral Director: /	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, a investigation, in my opinion, death occurre	and due to the car ed at the time, dat	use(s) and manner as stated. e and place, and due to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month, Day, Year)
	-		Ada Can	RES00000	9	126/08
			30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)		
			Dr. Adam Goodman 9000 Frank	In Square Drive	e Balti	more, MD 21237
	Sta Registr		31. Date filed (Month, Day, Year)  OCT 0 9 2009  32. Registrar's Signature			mone, MD 21237

DHMH 17 Rev 1/2001

Don's Hamilton

		For State Registrar		State of Ma	-	ertifica:				Reg. No.	nno	991.00
Physic			e (First, Middle, Las othy H. Ha	*					2. Date of De Month Octob	er 6,	Year 2009	3. Time of Death 2:35 P M
/Medi Examii				street and number)		4b. City	Town, or	Location of Death			inty of Death	2.33 1
, Examin	ici	Genes	is Health	Care			Caton	sville		Ва	1timor	e
Funeral Director		5. Social Security N 218-14-5		ex 7. Age □ M 2 🖾 F	(In yrs. last birtho	Months		If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da July 1	ay, Year)		lace (State or Foreign htry) yland
death with the Maryland ms 23a or 28a-f show rnust be notified at		Usual Residence of 10a. State	f Decedent 10b. County		10c. City, Town o	r Location					1	0d. Inside City Limits
Mar a-f st	ior	MD	Balti	imore	Cato	onsvil	Le					1 ☐ Yes 2 ☐ No
n the	ire	10e. Street and Nu	mber			10f. Zi	p Code			10g. Citizen	of What Cour	ntry?
th wit	la l	101 Bloc	omsbury Av	renue			21228			USA		
e = =	by Funeral Director	11. Marital Status 1 □ Never Mari 3 □ Widowed	ried 2 🔀 Married	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:	ever in U.S.	13. Was Dece If Yes, spe 1 ☐ Yes		ispanic Origin? (Sp in, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecifyWhite	etc.
in 72 hours aft a. "natural", or	Completed	(Spe	15. Decedent's Ed	ucation de completed) College (1-4or 5-		ecedent's Usi Give kind of wi fe. DO NOT t	ual Occup ork done d use retired	ation during most of work l)	ing	16b. Kind o	of Business/Inc	dustry
d within giene.	ĕ	12	oridary (0-12)	College (1 401 5		feteria	Wor				1 Syst	em
e filed al Hygin	Be (		(First, Middle, Last)					18. Mother's Nam	e (First, Middle	, Maiden Sur	rname)	
should be file and Mental Hy s marked oth	ျှ	James	Kaehler					Augusta				
es 1 and 2 should be of Health and Mental fittem 27 is marked or other traumatic even		19a. Informant's N	lame/Relationship (7	Type. Print)	19b. N	lailing Addres	s (Street	and Number or Rui	ral Route Numb	er, City or To	wn, State, Zip	Code)
C, IV			X. Hannor	ı, Jr. So				Avenue;			MD 212	
Pages 1 nent of H snt: If ite ury or ott		20a. Method of Dis		Removal from State	20b. Place of D cemetery,				Date		•	
. Pag tmen tant: jury		4 ☐ Donation	5 Other (Specify	)	Garriso	n Fores	st VA	Cem 10/	14/2009	Owing	s Mill	s, MD
permit. Pages Department of Important: If its any Injury or o			uneral Service Licen		10			ome of Ca				
		23a. Part 1. Enter shock, or he Immediate Cause	the disease, or compart failure. List only	olications that caused one cause on each lin	the death. Do no	t enter the mo	Edmo de of dyir	ndson Ave	or respiratory a	atonsv arrest,	iiie, i	pproximate Interval Between Onset and Death
Physician /Medical  Examiner		disease or conditi resulting in death)	on	a	a co sequence of)	me	7	Juni	~€			wks.
	ner	Sequentially list community, leading to in cause. Enter Und	onditions,	b. — Due to (of its :	s consequence of)	r .						
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g physician and as the burial-transit	edical E			d								
ath cert	Physician/Med	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2	2 months	4 ☐ Pregnant at	2 Fetal death	3 Ectopic		у		230	Date of deliv	rery Day Year
by the	hys	9 ☐ Unknow		9 🗌 Unknown								
w requires that the death cer been signed by the aftendir should be detached for use		Part II. Other sign	ificant conditions o	ontributing to death bu	ut not resulting in t	heunderlying	cause giv	en in Part I.				the cause of death?
	ompleted by								24a. Was auto perf		24b. Were auto prior to co death? 1  Yes	opsy findings available ompletion of cause of
ician: 1	e C	25. Was case refe	rred to medical					26. Place of Dea			1 🗆 1 e s	2 🗆 140
Physician: r this certific ral director,	.o	examiner? 1 ☐ Yes 2 ☐	100	Hospital: 1 ☐ Inpatie	nt 2 ER/Outp	atient 3 🗆 🗆	Oth Oth	er: 4 Nersing H	ome 5 ☐ Res	idence 6	Other (Speci	ify)
ffe ffe	ation: T	27. Manner of Dea 1 Natural 2 Accident	th 5 ☐ Pending investigation	28a. Date of Inju (Month, Date	ry 28b. Tir v, Year) lnj	ne of ury M	28c. Injui Wor 1 🗆	y at k? Yes 2 □ No	28d. Describe	how injury o	ccurred	
al or Attending safter death. In Director: After din by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28e. Place of Injubuilding, etc	ury - At home, farn c. (Specify)	n, street, facto	ry, office		28f. Location City or To	(Street and Nown, State)	lumber or Rur	al Route Number,
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier (Check only one)	1 Certifying Ph 2 Medical Exar	ysician: To the best on the basis on the basis on the basis on the basis on and manner sta	f examination and	death occurre for investigation	ed at the ti	me, date and place opinion, death occu	e, and due to the rred at the time	e cause(s) ar e, date and pl	nd manner as ace, and due t	stated. to the cause(s)
To th To th Comp	Me	29b. Signature an	title of certifier	Paro.				se number		29d. Date s	signed (Month,	Day, Year)
		30. Name and add	dress of person who	completed cause of d	eath (Item 23a) (T	ype, Print)	U.	16147	- (	1	616	7,2009 ~ 2,228
		175	TURAKU	MIA, ME	100	I, fr	cal	440 6	(d). (9)	Jor J	700,	0 4164
St Regist	ate	31. Date filed (Mo	nth, Day, Year)		ar's Signature	arke						

	1 - State Registrar  1. Decedent's Name (First, Middle, Last)		Pertificate of Death	2. Date of Death	J. No. 2019	3. Time of Death
Physician	Marion Ann Hecht			Month	Day Year	0009 M
/Medical Examiner	4a. Facility Name (If not institution, give street and the street of the	.)	4b. City, Town, or Location of De	ath	4c. County of Death	
Funeral Director	5. Social Security Number  388-22-4859  Usual Residence of Decedent	7. Age (In yrs. last birthd	Months Days Hours Mi		Year) 9. Birth Cour 1927 Wis	place (State or Foreigntry)  COnsin
tural", or items 23a or 28a-f show at Examiner must be 1x difficult at each of by Funeral Director	10a. State 10b. County  MD Baltimore	10c. City, Town or			1	0d. Inside City Limit
tor 28a-f st condition Director	10e. Street and Number	Catonsvi	10f. Zip Code	10	g. Citizen of What Cour	ntry?
3a or	713 Maiden Choice La	ne #2113	21228		USA	
Department or nealing and wenter hygens.  Important: If time 27 is an extend other than "natural" or items 23a or 28a-f show any injury or other traumatic event, it is Modical Examination must be notified at once.  To Be Completed by Funeral Director	1 □ Never Married 2 ☒ Married 1 □ If Ye 3 □ Widowed 4 □ Divorced Ye	]Yes 2∏XNo ′es, Give ar or Dates:	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu 1 □Yes 2 ☑ No Specify:		14. Race - Americ Black, White, Specify: Wh:	etc. i.te
t, it e Modes E Completed		oleted) (G lift llege (1-4or 5+)	ecedent's Usual Occupation live kind of work done during most of w e. DO NOT use retired)	rorking	6b. Kind of Business/In	dustry
S T E	17. Father's Name (First, Middle, Last)	+	Homemaker  18 Mother's N	ame (First, Middle, Ma	Own Home	
arked ott atic ever To Be	Isaac W. Stout			C. Nooney	,	
27 is ma	19a. Informant's Name/Relationship (Type. Pr. Robert E. Hecht, Sr.	, i	ailing Address <i>(Street and Number or</i> 3 Maiden Choice La			
y or othe	20a. Method of Disposition  1⊠ Burial 2 □ Cremation 3 □ Remove 4 □ Donation 5 □ Other (Specify)	arrom State	sposition (Name of crematory or other place)  In Cemetery 10/		Oc. Location - City or To	
Importar any injur once.	21. Signature of Funeral Service licenses	A.	22. Name and Address of Facility S Funeral Home of	terling As Catonsvill	hton Schwa	b Witzke
sician	23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one cau Immediate Cause (Final disease or condition	s that caused the death. Do not se on each line.	1630 Edmondson Avenuer the mode of dying, such as care	enue; Cato iac or respiratory arres	nsville, M st,	Approximate Interval Between Onset and Death
edical miner		Due to (or as consequence of):	1 15			2 2
By physician and as the burial-transit edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d	Oue to (or as a consequence of):				
signed by the attending pn d be detached for use as th d by Physician/Medi	in the past 12 months?	ves, outcome of pregnancy Live birth 2 Fetal death Pregnant at time of death Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of deliv Month	very Day Year
Id be deta	Part II. Other significant conditions contributi	ng to death but not resulting in th	ne underlying cause given in Part I.		acco use contribute to to	the cause of death?
I director, page 2 should				24a. Was an autopsy perform 1 □Yes 2	prior to co	opsy findings availal ompletion of cause o
After this certif funeral director ion: To Be	1 Natural 5 ☐ Pending	al: 1 Inpatient 2 ER/Outpa a. Date of Injury 28b. Tim (Month, Day, Year) Inju	atient 3 DOA Other: 4 Nursing the of 28c. Injury at Work?	Death (Check only one g Home 5 ☐ Resider 28d. Describe how	nce 6 Other (Spec	ify)
To the Funeral Director: After this completely filled in by the funeral director Medical Certification: To	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	e. Place of Injury - At home, farm, building, etc. (Specify)		28f. Location (Stre City or Town,	eet and Number or Rui State)	ral Route Number,
o the Fune ompletely fil	(Check only 2 Medical Examiner: C	on the basis of examination and/o	death occurred at the time, date and pl or investigation, in my opinion, death o	ccurred at the time, da	te and place, and due	
ple ple						
within To the comple	29b. Signature and title of certifier  Nicholas Tapas	oglow MO	29c. License number AS2438528 ppe, Print) Ave. Ba	4106	NO/7/07	, Day, Year)

		•	For State Registrar	State of Ma	aryland / Depa <i>Cei</i>	artment of Hertificate of C			ene eg. No. 7 () () ()	L 32402
ı	Physici		1. Decedent's Name (First, Middle EDNA CHA		NA			2. Date of Death Month OCTOBER		3. Time of Death 5:30 P M
my	/Medio Examin		4a. Facility Name (If not institution		N.C.	4b. City, Town, or	Location of Death		4c. County of Deatl	h
-			2606 Old Jopp		- (la como la et la telesta de la A	Joppa If Under 1 Year	If Under 24 Hrs.	O. D. L / Pint	Harford	
	Funeral Director		5. Social Security Number 231-05-2346 Usual Residence of Decedent	6. Sex 7. Ag 1 □ M 2 🛣 F	e (In yrs. last birthday) 93 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, June 14	Year) 1916 Co.	nplace (State or Foreign untry) Virginia
	ryland how	L	10a. State 10b. County	-	10c. City, Town or Lo	cation				10d. Inside City Limits
	he Ma 28a-f s	Director		ford	Joppa					1 ☐ Yes 2 X No
	23a or 2	ral Dir	10e. Street and Number 2606 Old Jopp	oa Road		10f. Zip Code 21085		10	ng. Citizen of What Co USA	untry?
21215-0036	i within 72 hours after death with the Maryland jene. r than "natural", or items 23a or 28a-f show the "wedeal Extrafrum", ust by praffiled at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☐ Marri 3 ☒ Widowed 4 ☐ Divorced	12. Was Decedent   Armed Forces?   1 □ Yes 2 ☑ If Yes, Give Year or Dates:	No	Was Decedent of His fYes, specify Cubar I□Yes 2∏ No	spanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify:	
15-0	72 ho "natur	eted	15. Deceden (Specify only highe	t's Education st grade completed)	(Give	dent's Usual Occupa kind of work done du	uring most of worki	ng I	6b. Kind of Business/I	ndustry
121	within iene. <b>than</b>	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) life. L	00 NOT use retired) nemaker	, and the second		Own Home	
	nt,	Be C	17. Father's Name (First, Middle,	Last)	1101		18. Mother's Name	(First, Middle, M		
Maryland		횬	Robert Edward					ce Willi		
Mai			19a. Informant's Name/Relations Robbin Walker						City or Town, State, Zlaryland, 2	
ore,	of H		20a. Method of pisposition		20b. Place of Dispos				20c. Location - City or	
Baltimore,	Pag ment ant: I		1反 Burial 2 □ Cremation 4 □ Donation 5 □ Other (S	pecify)	Darlingto	on Cemeter	y 10/9	/2009	Darlington	, Maryland
Bal	permit. Departr Imports any Inji		21. Sign true of Funeral Fervi	1 V JH	7	Name and Address Name and Address	ب		neral Home lon, Maryla	
			23a Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that caused only one cause on each lin	the death. Do not entene.		0		est,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a	gettive consequence of);	heart	failure			
	Examiner		Secure dally list or military	b. At	sal Fil	brillat	bu			
	uted d ansit	Examiner	Sequentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequence of):	s trucki)	e nu	1/mais	y Lixar	,
.09	ificate be executed g physician and as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):	<u> </u>	/		7 -1100	The second secon
	tificate ng phys as the	ledical		d						
). Box	ath cer attendir or use	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a	2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of del Month	ivery Day Year
P.O.	res that the de signed by the be detached f		9 ☐ Unknown  Part II. Other significant condition		ut not resulting in the un	nderlying cause giver	n in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ords	v requires been sign should be	ted by	Hyperte	4510u		, 0		1 □ Ye	s 2 <b>□ N</b> o 3 □ Pr	obably 4 🗆 Unknown
	75	Completed by	- Markins	ous				24a. Was an autopsy perform	prior to death?	topsy findings available completion of cause of 2 🏿 No
Vita	Physician; this certific	Be C	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	ent 2 □ ER/Outpatien	Othor	26. Place of Death	·	·	
n of	ing Phy After this uneral d	on: To	27. Manner of Death 1 Natural 5 □ Pendin	28a. Date of Inju	ry 28b. Time of			28d. Describe ho	nce 6 ☐ Other (Spec w injury occurred	cify)
visio	Attendi r death. ector: A by the fu	Certification: To	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could r	ation	ury - At home, farm, stre	M 1 □Y	es 2 No	28f. Location (Str	reet and Number or Ru	ıral Route Number,
ă	To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		4   Hornicide	J				City or Town,		
	ne Hos n 24 ho ne Fun pletely	Medical	(Check only 2 Medical one)	g Physician: To the best of Examiner: On the basis of and manner sta	f examination and/or inv	restigation, in my op	e, date and place, inion, death occurr	and due to the ca ed at the time, da	ause(s) and manner as ate and place, and due	to the cause(s)
	To the complete compl	Ň	29b. Signature and title of certifier	11		29c. License	2-22		d. Date signed (Month	-
		-	30. Name and address of person	who completed cause of d	eath (Item 23a) (Type, I	Print)			10/00/2	009
			Robert S. K.	night, MD 1	of Pluetre	e Road	Sk 102 B	el Air,	Mary land	1 21015
	Sta Registra		31. Date filed (Month, Day, Year)	32. Hegistra	ar's Signature	a. 16. 1				

DHMH 17 Rev 1/2001

Physici /Medic

#### State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Examir

**Funeral** Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. "natural", or items 23a or 28a-f show any liupy or other traumatic event, it a Medical Examination to moffied at any liupy or other traumatic event, it a Medical Examination to moffied at any pince.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

ital or Attending Physician: The law requires that the death certificate be executed us after death. ral Director: After this certificate has been signed by the attending physician and lled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760, ℜ

	To the Hospi	within 24 hour	To the Funer	completely fill	
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			D.	S	Sta

	1 - For State Registrar		,	Cei	rtificate of	Death	,	Reg. No	0,	1 0	17	400
	1. Decedent's Name (First, Middle, La	ast)					2. Date of De		av	Vear	3. Time of	Death
an :al	Josephine Emmai	Lee Houck		_			Octobe				3:30	рM
er	4a. Facility Name (If not institution, gi	ve street and number)			4b. City, Town, o	Location of Death		40	c. County	of Death		
	Laurel Regional	Hospital			Laurel							
		Sex 7. Ag 1 □ M 2 🕱 F		ast birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	rth a <i>y, Year</i>	2	9. Birthp	place (State of	or Foreign
	233-34-0881	TO MI ZLALF	8	5 Yrs.			March	10,	1924		/W	7
	Usual Residence of Decedent  10a. State 10b. County		10c. City	, Town or Lo	cation					1	0d. Inside Ci	ity Limits
ō	WV Berkley	,	Hedo	gesvil	10						1 ∐Yes	2 ₽ No
ect	10e. Street and Number		cu		10f. Zip Code			10a C	itizen of \	What Cour	ntrv?	
	2118 Mountain La	ke Poad			25427					William Godi	y .	
era	11. Marital Status	12. Was Decedent	Ever in 11.5	3 13 1		ispanic Origin? (Sp	ecify Yes or No		3. Time of Death 3:30 p M County of Death Prince George 9. Birthplace (State or Foreign Country) WV  10d. Inside City Limits 1			
Fur	1 ☐ Never Married 2 ☐ Married	Armed Forces?				lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)					
β	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		'	1⊡Yes 2.XXNo	Specify:			Specif	y: whi	te	
Completed by Funeral Director	15. Decedent's E	ducation	1		dent's Usual Occup			16b. I	Kind of B	usiness/In	dustry	
ed.	(Specify only highest gr	College (1-4or	5+)	life. I	DO NOT use retired	during most of work d)	ing					
Š	12			Homem	aker			Ow	n Hoi	me		
Be (	17. Father's Name (First, Middle, Las	t)				18. Mother's Name	e (First, Middle	e, Maide	n Surnan	ne)		
မှ	Arnold Luikart					Flora B	utcher					
1	19a. Informant's Name/Relationship	(Type. Print)		19b. Mailir	ng Address (Street	and Number or Rui	ral Route Numb	ber, City	or Town,	, State, Zip	Code)	
	Sheri Jayne Lowe	e/ Daughte:				ry Street						
	20a. Method of Disposition  12 □ Cremation 3 [	Removal from State	20b. Pl	ace of Dispo emetery, cren	sition (Name of natory or other plac	e) Octo	Date Ser 9,	1		•		
	4 □ Donation 5 □ Other (Special		Bro		Cemeter		000	1				
	21. Signature of Funeral Service Lice		01053	3	2. Name and Addre 13 Talbot	ss of Facility Do	naldsor Laurel,	n Fui MD	nera: 207	l Hom 07	e, P.A	4.
	23a. Parl 1. Enter the disease, or con	nplications that cause	d the death	. Do not ent	er the mode of dyir	ng, such as cardiac	or respiratory a	arrest,			Approximat	e
	sTock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition Sepsis								Onset and	Death		
	disease or condition resulting in death)  a. Sensis  Due to (or as a consequence of):								_			
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ner	Sequentially list conditions, if any, leading to immediate cause. Entire Underlying Cause (Disease or injury	Due to (or as			00020.							
ami	that initiated events	c. Ovaria	n Can	cer								
<b>Medical Examiner</b>	resulting in death) Last	Due to (or as	a consequ	ence of):								
ica		d				****************						
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an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 \sum Live birth	2 Fetal	death 3	∃Ectopic pregnanc	у		1			•	Voor
Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant a 9 ☐ Unknown	at time of de	eath 5	Other (specify) _				IVI	onu i	Day	1001
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by	Part II. Other significant conditions	contributing to death t	ut not resu	iting in the ti	ilderlyllig cadse giv	en arranti.						
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nple.							24a. Was	psy	24b.	prior to co	psy findings mpletion of c	available ause of
Sol							perf 1 ☐ Yes	ormed? 2√2√N	lo	death? 1 □ Yes	2 No	
Be	25. Was case referred to medical examiner?	Manifel			Lou	26. Place of Deat	h (Check only	one)				
2	1 Yes 2 No				nt 3 □ DOA Oth	4 Li Nuising H					fy)	
ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ary ay, Year)	28b. Time of Injury	Wor		28d. Describe	how inju	ury occur	red		
cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not to	10				Yes 2 □No	006.1					
ırtil	4 Homicide determined				eet, factory, office		City or To			ber or Rura	al Route Nun	1ber,
Medical Certification: To	29a. Certifier XXCertifying P	hyeiclan: To the heat	of my bac	alledes dest	h accurred at the 41	me data and alas-	and due to th	0.001.00	(a) and	annorna	etated	
lica		hysician: To the best miner: On the basis of and manner st	of examinat									3)
Mec	29b. Signature and title of certifier	and manner st	aleu.		29c. Licens	e number		29d. D	ate signe	ed (Month	Day, Year)	
	1/2	0. 1.				λ	ا ع					
	30. Name and address of person who	completed assess of	donth /lt	99a) (Time	Drint\	1005570	2 2	00	-cobe:	r 3,	2009	
	Tsion. Berhane.					ordale M	D 20730	1				

31. Date filed (Month, Day, Year)
OCT, 0 9 2009

32. Registrar Signature

			Type or Pri State of M						Ensure A	_		_		
	•	1 - For State Registrar				Cert	ificat	e of l	Death		Reg. No.		9 3210	1
Physicia		1. Decedent's Name (First, Middle, La	Martha	М.	Her	r				2. Date of De Month Octobe	Dav	, 200 <sup>Year</sup>	3. Time of Death 11:50 PM	
/Medic Examin		4a. Facility Name (If not institution, gi	ve street and number,	)		-	1b. City,	Town, or	r Location of Deat	n		County of Deat	h	-
LXamm		Potomac Valley Nurs	ing and Well	lness	Cente	er	]	Rock	ville		1	Montgome	ery	
Funeral		Social Security Number     6.		ge (In yrs.	last birti	hday)	If Under Months	1 Year Days	If Under 24 Hrs. Hours Min.	(Month Da	v Year)	Co	hplace (State or Foreign buntry)	Ī
Director		207-01-2467 Usual Residence of Decedent		90		15.				August 1	/, 1	919   Pen	nsýlvania	_
yland now		10a. State 10b. County		10c. Cit	y, Town	or Loca	tion						10d. Inside City Limits	Ī
e Mar la-fsl	Director	Maryland Mont	gomery		I	Rock	vill	.e					1 ŽiYes 2 □ No	
or 28	Dire	10e. Street and Number					10f. Zip					izen of What Co	-	
ath w	ral	13105 Ardennes A							0851			ted Star		_
er deg	Funeral	11. Marital Status	12. Was Decedent Armed Forces	?	S.	13. Wa	as Deced es, spec	lent of H cify Cuba	lispanic Origin? (S an, Mexican, Puer	specify Yes or No to Rican, etc.)	-	<ol> <li>Race - Ame Black, White</li> </ol>		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it a Medical Examinar mant to incline a soluce.	by F	1 ☐ Never Married 2 ፟ Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 ☐ If Yes, Give Year or Dates:	WV	JII	1[	Yes 2	2 <b>⊠</b> No	Specify:			Specify: W	nite	
2 hou		15. Decedent's E					nt's Usua			rleimer	16b. K	ind of Business/	Industry	-
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ed wi lygier ner th	ပ္ပံ		2		Re	gist	tere	d Nu		/Floor Adjoint		ursing		_
be fil	Be	17. Father's Name (First, Middle, Las Edward Palevic								<sub>ne (First, Middle,</sub> ha Bonin		i Surname)		
hould d Me mark matic	ပ	19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zin							Zin Code)	-				
d 2 s Ith an 17 Is i		Andrew E. Herr /	, ,,						Avenue,					
t and f Health tem 27		20a. Method of Disposition	nabbana	20b. F			tion (Nar			Date		ocation - City or		-
Pages nent of ant: If ite ary or o		1 X Burial 2 ☐ Cremation 3 D 4 ☐ Donation 5 ☐ Other (Spec		9			en Ce			ober 2009	Silv	er Spring	, Maryland	
permit. Departm Importa any inju		21. Signature of Funeral Service Lice	ensee 🗘			22. Dob	Name ar	d Addre	ss of Facility mphrey Fund					-
a E L		Angelette Ban	AKO M	10130	5	300	West	Mont	tgomery Ave	enue, Rock	ville	Marylar	nd 20850-2805	_
		23a. Part 1. The the disease, or cor shock, or heart failure. List only	nplications that cause one cause on each l	ed the deat line.	h. Don	ot enter	the mod	le of dyir	ng, such as cardia	c or respiratory a	ırrest,		Approximate Interval Between	
Physician		Immediate Cause (Final disease or condition	_a Alzhe										Onset and Death	
/Medical Examiner		resulting in death)	Due to (or as	s a conseq	uence c	of):								
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rtifica ng ph as th	/ledi	IE EEIWALE												_
eath certific attending p for use as	an/I	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 ☐ Live birth			3 🗆 1	Ectopic p	regnand	су			23d. Date of de Month	livery Day Year	
at the dea by the ar tached fo	Physician/Medical	1 ☐ Yes 2 🛣 No 9 ☐ Unknown	4 □ Pregnant 9 □ Unknown	at time of o	death	5 🗆 (	Other (sp	ecify) _				Month	Day Tour	
hat the sed by Jetach		Part II. Other significant conditions	contributing to death	but not res	ultina in	the und	erlvina c	ause div	ven in Part I.	23e. Did	tobacco	use contribute to	o the cause of death?	-
Physician: The law requires that the death certificate be this certificate has been signed by the attending physiciaral director, page 2 should be detached for use as the bur	d by	Chronic Obstruct	-		_		,	3		1 🗆	Yes 2	□ No 3 □ P	robably 4 🔀 Unknown	
w requir been si should I	Completed									24a, Was	an	24b. Were a	utopsy findings available	-
he lav e has	mc									auto		prior to	completion of cause of	
sician: The law certificate has b irector, page 2 s		25. Was case referred to medical	1	-					26. Place of De	1 ☐ Yes ath (Check only		1 ⊔Ye:	s 2 No	-
ysictis cer	o Be	examiner? 1  Yes 2 <b>X</b> No	Hospital: 1 ☐ Inpat	tient 2	ER/Ou	tpatient	3 🗆 D0	Oth	or	Home 5 ☐ Res		6 ☐Other (Spe	ecify)	_
<b>70</b> 00 00	J:uc	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of In			ime of	2	28c. Inju	ry at rk?	28d. Describe	how inju	iry occurred		
Attending ir death. ector: After by the funer	atic	2 ☐ Accident investigation	on				М	1 🗆	Yes 2□No					
or Att	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	20e. Place of it	njury - At h etc. <i>(Speci</i>	ome, far <i>fy)</i>	rm, stree	et, factor	, office		28f. Location ( City or To	Street a wn, Stat	nd Number or A e)	ural Route Number,	
pital ours a eral C		29a. Certifier 1 Certifying F	Physician: To the bes	t of my kny	nwledge	death	occurred	at the ti	ime, date and plac	e, and due to the	e cause/	s) and manner a	as stated.	_
To the Hospital or Attending within 24 hours after death.  To the Funeral Director: After completely filled in by the fun	Medical	(Check only one)	miner: On the basis and manners	of examina	ation an	d/or inve	estigation	n, in my	opinion, death occ	urred at the time	, date an	nd place, and du	e to the cause(s)	
ithin mp	Me	29b. Signature and title of certifier					29	c. Licens	se number		29d. Da	ate signed (Mon	th, Day, Year)	_

State Registrar

DHMH 17 Rev 1/2001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Piyush Patel, M.D. 12001 Ferrara Avenue, Wheaton, Maryland 20906

31. Date filed (Month, Day, Year)

OCT 0 9 2009

32. Poistor's Signature

D0056345

October 8, 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death TACKSON 900 AM **Physician** Year Octobe 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL Randallstown Baltimore orth West 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 12 29 195 Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) 1 ☐ M 2 💢 F 218.14.09.28 3 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ir than "natural", or items 23a or 28a-f show the Wedical Evantions quist by notified at Pikesville 1 ☐ Yes 2 No Director MID Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21208 Hannah by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 'Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, trawany injury or other traumatic event, trawang ones. Elementary/Secondary (0-12) College (1-4or 5+) Private 17. Father's Name First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Griffin Ben Bewah Lauis ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ackson 25 At Hannah Circle Pikesville MD 21208 nius L 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ■ Burial 2 □ Cremation 3 □ Removal from State Baltimore, MD Arbutus Memorial Park 1912/09 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Virugen C. Greene Funeral Suco 21. Signature of Funeral Service Licenses iberty Road Randallstown MD 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical **Examiner** bdominal Infection. Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, burial-trar Due to (or as a consequence of): physician the burial Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day Month Year 5 ☐ Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ driknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy perform 2 Z NO 1 ☐ Yes 2 ☑ No 1 🗆 Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death To the Funeral Director: the 1 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical completely and manner stated. 29b. Signature and title of certifier 7,2009

State Registrar 5401 Old Court Road, Randallstown, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Marrouni

31. Date filed (Month, Day,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1- For Amend Items 1,24a,25 per dr.,8896,10/09/09dbb
Registrar Registrar Registrar Registrar 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death BER ED Year Jaylin **Jennings Physician** Jennins /Medical 4c. County of Death 4b. City, Town, or Location of Death Eacility Name (If not institution, give s Examiner DITTE 10FB LAMOIZ LOYC 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1**X** M 2□ F Baltimore MD 0 05-20-1999 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show injury or other traumatic event, the Medical Examiner must be notified at Randallstown 1 XYes 2 □ No Baltimore by Funeral Director MD 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a or 21133 3424 U.S.A arriage Hill Cir Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 NNo
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. or items 11, Marital Status filed within 72 hours after 1 Never Married 2 ☐ Married 1 □Yes 2 No Specify: Specify: Black 3 Widowed 4 Divorced natural Be Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Student School 3 grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be **t**aul lamara -eaK Jennings ပ Department of Health and Me Important: If item 27 is mark any injury or other traumatii 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) L. Jones (mother) 3424 Carriage Hill Cir Randallstown MD 21133 lamara 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other p 20a. Method of Disposition Date Pages 1 1 MBBurial 2 ☐ Cremation 3 ☐ Removal from State King MeMorial Park Windsor Mill MD 4 Donation 5 Dother (Specify) 814 Upshur St N.W. o of Funeral Service Licensee State Funeral Services Washington DC. w. Vac Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) WAC allos **Examiner** if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed Due to (or as a consequence of) burial-Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Dav in the past 12 months? 4 Pregnant at time of death 9 Unknown 5 Other (specify) 1 □Yes 2 □ No detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2X No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autops, performed? Ves 2X No or Attending Physician: The this certificate 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 \( \text{Nursing Home} \) 5 \( \text{Plane Residence} \) 6 \( \text{Other (Specify)} \) 1XYes 2 □ No 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 1 Matural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hin 24 hours after death the Funeral Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated. within To the 29b. Signature and title of certifier 29c, License number

State Registrar 1. Date filed (Month Try) (Year) 2009

32. Registrar's Signature

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Bathaure all

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 641 Jasinski Cecelia C. AM 2009 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FRANKLIN Square Hospital Center BalTimore Rosedale If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, 1 □ M 2 💢 🗲 Months Days Hours 88 218-07-2359 April 10, 1921 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Parkville MD Baltimore 1 ☐ Yes 2**X**]**X**(o 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 21234 3339 Texas Avenue 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes XXNo Specify: Specify: White 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Beauty Salon 8 Hairdresser 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Stanley Koterwas Stella Koterwas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Palmeri -Daughter 3339 Texas Avenue, Parkville, MD 21234 20b. Place of Disposition (Name of cemetery, crematory prother place) Garciers of Faith 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) oct. 12,2009 Baltimore, MD Chrietery 22. Name and Address of Facility Evans Funeral Chapel & Cremation Services — Parkville 21. Signature of Funeral Service Lidensee 8800 Harford Road, Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) myocardiat In facction Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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ed other than "natural", or items 23a or 28a-f show event, it a Medical Examiner must be notified at

and Mental Hygiene. is marked other than

permit. Pages 1 and 2 Department of Health a Important; If item 27 is any Injury or other trai

and 2 should be lealth and Mental

death v

Ceceli

Baltimore, Maryland

Box 68760

P.O.

Records,

Division of Vital

sician and burial-trans attending physician the as use for

Examine signed by the a page 2 should has this certificate Hospital or Attending Physician: 24 hours after death. Certification: To within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

Physician/Medical 2 Completed Be

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No

performed? Yes 2 No

1 ☐ Yes

26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

5.		referred to medical	
	examiner? 1 🗌 Yes	2 17/10	
	1 163	2 110	

27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide

6 ☐ Could not be 4 Homicide

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier 30. Name and address of pera-

NGUYEN

065094

-2009

DR BIN 31. Date filed (Mon n who completed cause of death (Item 23a) (Type, Print) 8,000

FRANKLIN Square DR Batto md 21237

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10d, e, & f, 16a-b, per Fh g897 11/2/09 TT

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death **Physician** Year 30 /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner Funeral** Yrs. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10b. Count 10c. City, Town on Locati 10a State 10d. Inside City Limits Examiner must be notified at Director 1 2 X No 10e. Street and Number Lawnwood Circle 10g. Citizen of What Country by Funeral 12: Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White etc Never Married 2 ☐ Married altimore, Maryland 21215-0036 Specify: 1 ☐ Yes 2 No Specify: 7 Is marked other than "natural", traumatic event, the Medical Exa 3 ☐ Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation Never Worked ind of Business/Industry Worked Decedent's Education (Specify only highest grade completed) (Give kind of work done life. If O NOT use retire Elementary Secondary (0-12) College (1-4or 5+) (First, Middle ျှ item 27 of Disposition (Name of teny clematory or other place) Methed of Disposition Department of Important: If it any injury or o Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Liced 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Gequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an certificate has Y□Yes 2 MNo To the Hospital or Attending Physiclan: 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide † Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifiei (Check only one) 29b. Signature and title of certified D24698 10-07-2009 LUCH RAVEN BLUD BALTIMORE 21210 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHER A HASHMI HID 39.00 LDC

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

9

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death RAYMOND **Physician** JOHN Month Day KRUL 7:25P /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Center Saint Joseph Medical imore Towson 5. Social Security Number Funeral 6. Sex 7. Age (In yrs. last birthday) 85 Yrs. If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 3-27-1924 9. Birthplace (State or Foreign Months 1X M 2 □ F Days Hours Min 217-18-3834 MARYLAND Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 Is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, If we Medical Examinar must be profiled at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD BALTIMORE Director PARKVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2808 SUMMIT AVENUE 21234 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: WWII 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No **6** Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Specify: Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENTREPRENEUR SELF EMPLOYED 17. Father's Name (First, Middle, Last)
JOSEPH 18. Mother's Name (First, Middle, Maiden Surname) MARY (SETERA) KRUL ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ESTHER M. KRUL/WIFE 2808 SUMMIT AVENUE PARKVILLE, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State DULANEY VALLEY MEM. GARDEN 10-10-09 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE ROSEDALE, 21237 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE MYOCARDIAL INFARCTION /Medical resulting in death) Due to (or as a consequence of): Examiner CORONARY ARTERY DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical attending p for use as t IF FEMALE If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Dav 5 Other (specify) Year ed by the a 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown After this certificate has been signed by funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? METASTATIC PROSTATE CANCER Be Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown LACTIC ACIDOSIS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 □Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physician: 'within 24 hours after death.'

To the Funeral Director: After this certifica 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 Accident 1 □Yes 2 □ No the 3 ☐ Suicide 6 Could not be à 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 156 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) intt D31826 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32 M. D. OSLER DRIVE TOWSON. MARYLAND 21204 7601 32. Registrar's Signature State ULI U & ZUUS Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Purnell Kelly 3.04 2010 2009 06 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Himore NA Hospita 5. Social Security Number Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 8. Date of Birth (Month, Day, Year) 08-14-39 7. Age (In yrs. last birthday) Days Country 1 XM 2 F Months Hours Min. 70 Yrs 213-34-6046 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Baltimore Catonsville MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 908 Marksworth Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African 1 Never Married 2 Married 1⊡Yes 2∐Xio If Yes, Give Year or Dates Specify: Specify: American 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mass Transit Elementary/Secondary (0-12) College (1-4or 5+) Administration 12th Grade Driver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pearl Kelly Buddy Kelly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 Marksworth Road Catonsville, MD 21228 Gloria M. Kelly-Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-20-09 Owings Mills, MD Garrison Forest 21. Signature of Funeral Service Licensee Wylie Funeral Home P.A. 22. Name and Address of Facility 638 N. Gilmor Street Baltimore, MD 21217 23 art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) J'Onl'C Oh structure 100-C Due to (or as a consequence of): Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown ) icholog melliku 24b. Were autopsy findings available prior to completion of cause of death? y parter sinn 24a. Was an autopsy onjestine 2 🔀 No Hours 1 □ Yes 2 No 1 ☐ Yes 26. Place of Death (Check only one)

**Physician** /Medical Examiner

Important: If it any Injury or o

Exami

Physician/Medical

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Completed

Be

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Certification:

Medical

**Physician** 

Examiner

**Funeral** 

Director

ral", or items 23a or 28a-f show Examiner must be notified at

Director

Funeral

2

Completed

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

/Medical

attending physician and for use as the burial-trar been signed by the should be detached ij within 24 hours after death

To the Funeral Director:
completely filled in by the

has

certificate

The law requires that the death certificate be executed

Records, P.

Vítal

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Division

To the Hospital or Attending Physician:

25. Was case referred to medical examiner? 1 Yes 2 → 27. Manner of Death

5 Pending investigation 1 Natural 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year)

Hospital:

28b. Time of 28c. Injury at Work? 1 ☐ Yes 2 ☐ No Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2] Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifier

29c. License number

29d. Date signed (Month. Day, Year) 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Buskyan 3455 rce 10 31. Date filed (Month, Day, Year) 32. Registrar's Sign

State Registrar

within 2.

09-07704 Wona Chul Kim

## Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

vong Chui Killi	1- For State Certification 1- For State Certific	ate of Death	Reg. N	o. • n r	0011
Physician Medical Examine	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month Day October 4, 20	/ Year	3. Time of Death. 3. 1235 hrs
/ /	4a. Facility Name (if not institution, give street and number)  Carroll Hospital Center	4b. City, Town, or Location of Death Westminster		4c. County of Death	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birt 2.19-90-3304 1 6. Sex 6	Months Days Hours Min	C	CO	hplace (State of 1 , n SEOU1 , untry) Korea
Aaryland 28a-f show any 1 at once.	Usual Residence of Decedent  10a. State  10b. County  Maryland  Baltimore	Timonium			10d. Inside City Limits  1 Yes 2 No
th the Maryl 23a or 28a- notified at 6	10e. Street and Number 2108 Folkstone Road	10f. Zip Code 21093	Ū	Citizen of What Cour nited Sta of Americ	tes a
r death wi	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	13. Was Decedent of Hispanic Origin? ( S If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No specify:	pecify Yes or No- p Rican, etc.)	14. Race - Ameri White, etc.	korean
5-0036 led within 72 hours afte Hygiene. other than "natural", the Medical Examine.	or Dates:	Decedent's Usual Occupation (Give kind of during most of working life, DO NOT use re	tired)	b. Kind of Business/	
21215-0036 July be filed within 7 Mental Hygiene: marked other than ic event, the Medica	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  12  17. Father's Name (First, Middle, Last)		e (First, Middle, Maid Rye Kiin	Grocery S	tore
MD 2121; nd 2 should be fill lith and Mental I m 27 is marked aumatic event, 1	Hak Chun Kim  19a. Informant's Name/Relationship (Type, Print)  Mrs. Jade K. Allen/ daughter	b. Mailing Address (Street and Number or 346 White Road Wats	Rural Route Number	, City or Town, State Californi	e, Zip Code) La 95076
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygene. Important: If item 27 is marked other than " injury or other tranmattle event, the Madral	20a. Method of Disposition  1 X Burial 2 Cremation 3 Removal from State Dulan  4 Donation 5 Other Specify:  Memo	ev vallev i i	ctober	c. Location - City or	
Balti Departir Importir injury o	21. Signature of Funeral Service Licensee  23a. Part I. Enter the disease, or complications that caused the death. Do n	2. Name and Address of Facility Cacceful Alternative 2325 York Road Too ot enter the mode of dying, such as cardiac	imonium. M	arvland 2	21093 Approximate Interval
xaminer	fallure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  The fallure is a consequence of the condition of t				Between Onset and Death
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated (Disease or Injury that initiated				
recuted - transit	events resulting in death) Last Due to (or as a consequence of):	896 10-9-09 vt			
O, be expected by the control of the				00d Data of deliver	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	23b. Was decedent pregnant in the past 12 months?	2 Fetal death 3 Ectopic pregr 5 Other (Specify)	nancy	23d. Date of deliver Month	ry Day Year
P.O. B res that the d signed by the be detached		ng in the underlying cause given in Part I.			o the cause of death?
Division of Vital Records, P.C. To the Hospital or Attending Physician: The law requires that within 24 hours after death. To the Funeral Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be deta	Completed		24a. Was an autopsy performe	prior to death?	utopsy findings available completion of cause of
an: ]	25. Was case referred to medical examiner?	26.Place of Death (Chec	k only one)		
Vite of this of	examiner?  1 V yes 2 No  1 No 128a Date of Injury 28b	Outpatient 3 DOA Other Nurs	sing Home 5 Re	sidence 6 Othe	er:
Sion of Attending Pt death. retor: After	27. Manner of Death 1  Natural 5 Pending 2 Accident Investigation	Time of Injury 28c. Injury at Work?  1 Yes 2 No	28d. Describe how		
Divis To the Hospital or A within 24 hours alone completely filled in b	1 V Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  29a. Certifier Coult in Plans Investigation (Specify)	farm, street, factory, office building, etc.	or Town, State	e) 	Rural Route Number, City
To the II. within 24 To the Ft	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.  29b. Signature and title of certifier	eath occurred at the time, date and place, all investigation, in my opinion, death occurred 29c. License number	d at the time, date and	d place, and due to the signed (M	the cause(s)
	Carol Hallan	O.C.M.E.		October 5, 2009	
ý Sta	20 Paristrado Signatura	Penn Street, Baltimore, MD 212	201		
Registr	0.000 0.00000 0.0000	pares			

DHMH 17 Rev 1/2001 OCME 2006

			1 - For Amend Item	State of Marylan 28e per dr., g89	nd / Departmen 6,10/09/09 Certifica	ot of Health and M Inb te of Death	ental Hygien Reg. N	e • 2000	901.10
	Physicia	an	1. Decedent's Name (First, Middle,		7)	l'ine	Date of Death     Month     Date	ay Year	3. Time of Death
	/Medic Examin	al	4a. Facility Name (If not institution,	give street and number)	Lump's	, Town, or Location of Death	SEPTEMBE 4	C. County of Deatl	
7	Funeral		ST AGN  5. Social Security Number 6	Sex 7. Age (In yrs.	147.1		8. Date of Birth (Month, Day, Year	9. Birtl	hplace (State or Foreign untry)
	Director	t	315-40-1479 Usual Residence of Decedent	1□M 20 F 70	Yrs.	Days Hours Min.	Sept. 24, 19	739 M	aryland
	Maryland	tor	10a. State 10b. County	10c. Cit	ty, Town or Location	more,			10d. Inside City Limits 1 Yes 2 □ No
	h with the	al Director	10e. Street and Number 439 Ya	le Ave	10f. Zi	p Code 21229	10g. C	Citizen of What Co	untry?
9036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumaite event, the Medical Examination in the modified at	d by Funeral	11. Marital Status  1 Never Married 2 Marrier  3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1	.S. 13. Was Dece If Yes, spe 1 □Yes	edent of Hispanic Origin? (Sp acify Cuban, Mexican, Puerto 2200 Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify:	
1215-0036	within 72 h iene. • than "natu	ompleted	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed)  College (1-4or 5+)	16a. Decedent's Usu (Give kind of wo life. DO NOT u	ork done during most of work use retired)	ing 16b.	Kind of Business/I	s Halth
ै <del>८</del> land 21	id be filed vental Hyginked other	To Be Co	17. Father's Name (First, Middle, La	- C 11	Villiam		e (First, Middle, Maide	n Surname)	ams
#28e Maryland	r 2 mg	-	19a. Informant's Name/Relationship		19b. Mailing Addres	s (Street and Number or Rur	al Route Number, City	or Town, State, Z	Zip Code)
264 more,	ë = 5		20a. Method of Disposition  1 Burial 2 Cremation 3  4 Donation 5 Other (Spe	Removal from State	Place of Disposition (Na cemetery, crematory or	me of other place)	Date 20c. 1	Location - City or	Town, State
+26	permit. Page De artment of Important: If any injury or on		21. Signature of Funeral Service Li		0- 00077	nd Address of Facility  P. March	270 Fre	dHILTE Da oto	n Pass md. 21229
,			23a. Part t. En or the riscase, or co shock, or heart brure. List or	omplications that caused the eath		•	or respiratory arrest,		Approximate Interval Between Onset and Death
NO	Physician /Medical		Immediate (a) se (Final disease or condition resulting in death)	a.  Due to (or as a conseq	monany	Embolum			Onset and Death
	Examiner	_	Sequentially list conditions	b.	derice oi).				
Z	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	Due to (or as a conseq	uence of):				
S T T 68760,	ificate be executed g physician and is the burial-transit	edical Exa	resulting in death) Last	Due to (or as a conseq	uence of):				
SNE O. Box	cert nding se a	Physician/Medi	IF FEMALE: 23b. Was decedent preparant in the past 12 months? 1 □ Yes 2 TW10 9 □ Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of c	al death 3 Ectopic			23d. Date of del Month	ivery Day Year
rds, P.	es tha igned be de	by	Part II. Other significant condition	s contributing to death but not res	ulting in the underlying o	cause given in Part I.			the cause of death?
S,	e law has t	Completed					24a. Was an autopsy performed?	prior to death?	itopsy findings available completion of eause of
Vital N	ician: certific rector,	Be	25. Was case referred to medical examiner?	Hospital:	/	Other:	h (Check only one)		
5	ig Phys ter this neral dii	n: To	1 Yes 2 No 27. Mann of Death	1 ☐ Inpatient 2 ☑  28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	OA Unier. 4 Nursing Ho 28c. Injury at Work?	me 5 ☐ Residence 28d. Describe how inj		cify)
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	1 Natural 5 Pending 2 Accident investigat 3 Suicide 6 Could no determine	tion t be 28e. Place of Injury - At he	M M	1 □Yes 2 □No	28f. Location (Street a	and Number or Ri	ural Route Number,
	spital or ours afte neral Dir filled in		4 Tromicide	building, etc. '(Specification of the best of my known of the best of my known of the best of my known of the best	Home	at the time, date and place	City or Town, Sta		s stated
1	the Hos nin 24 h the Fur npletely	Medical	(Check only 2 Medical Ex	kaminer: On the basis of examina and manner stated.	ation and/or investigation	n, in my opinion, death occur	red at the time, date a	nd place, and due	e to the cause(s)
	To with	2	29b. Signature and title of ertifier			C. License number	I	Date signed (Monti	
	(0)		30. Name and address of person will	no completed cause of death (Iter	m 23a) (Type, Print)	8 <i>P</i> 9619430 enne, Baltimo	x	MINISTER	21,2001
	Sta	to	Dr. Pattani, St. 49 31. Date filed (Month, Day, Year)	nes Huspital 900	O caton An	enne, Bultime	ne, Many	land, Z	1229
	Registra		OCT U 9 ZUU		part				

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** William Lubis October 2009 12:15 PM /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 8657 Resevoir Road Howard Fulton Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1XXM 2□ F Director 206-16-4855 Jan 31. 1925 Pennsylvania Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 27 Is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Eventing that be rollified at 1 X Yes 2 No Funeral Director Howard Fulton 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20759 U.S.A. 8657 Resevoir Road 12. Was Decedent Ever in U.S. Armed Forces? 1 IXYes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) Musician Marine Corps 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Ushock Theodore Lubis 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8657 Resevoir Road, Fulton, Maryland 20759 Beulah Carr Lubis /spouse 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Emmanuel Cemetery Oct 7, 09 Scaggsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part1. Enter the issuase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or has a failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Large cell B cell lymphoma 1 month /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 1 Live birth 2 Fetal death in the past 12 months? Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗆 No 1 □Yes 2 X No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 X Natural 5 Pendina 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this continuous P.0. Division of Vital Records, I Director: A filled in by

State Registrar 29a. Certifier

29b. Signature and title of certifier

Koutrela MU 16710 32. Registrar's Synature

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

D38509

OCtober 5, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Charter Dr., Suite GOZO

Columbia, My 21044

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT. **Physician** 05:30 2009 Ruth P. Lloyd /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Harford Co. Upper Chesapeak Medical BEL ALL

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Year | Year | Year | Jan. | 16,1921 Center Bel Air 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🛣 F 163-18-3344 88 Maryland Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-1 shot any Injury or other traumatic event, the Medical Examination as the matther at Director Maryland Harford Co. 1 ☐ Yes 2X No Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 727 Rock Spring Road 21014 United States Funeral 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐Yes XXNo Specify: 21215-003 Specify:White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Maryland Insurance College (1-4or 5+) Elementary/Secondary (0-12) Buisness Owner Service 12 N/A Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evan L. Pieper Nellie M. Gross 19a. Informant's Name/Relationship (Type. Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Dee Dee Barnhill (Daughter) 798 Moores Mill Road, Bel Air, MD, 21014 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State Date 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State Evans Funeral Ch. 10/7/2009 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License Evans Funeral Chapel & Cremation Services 3 Newport Drive, Forest Hill, MD 21050 23a. Part 1. Enter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): physician and the burial-transit resulting in death) Last Due to (or as a consequence of): 68760 Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) \_ o 9 Unknow σ. signed to be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cate has t 24a. Was an autopsy perform certificate Vital 1 ☐ Yes 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ₩ No After this of 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending i within 24 hours after death. 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐Yes 2 ☐No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my prince 29a. Certifier (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) schedle Drive Bel Air MD

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

345

		State of Maryland / Department of State	artment of Health and N		0					
		Registrar	rtificate of Death		. No. 2 U U 9	32416				
Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Death     Month	Day Year	3. Time of Death				
/Medic	al	Louise W. Lucas		October 6,	2009	8:30 A <sup>M</sup>				
Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death					
		Northampton Manor Health Care Center  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Frederick If Under 1 Year   If Under 24 Hrs.	9 Date of Birth	Frederic	k place (State or Foreign				
Funeral Director		578-03-0222 1□ M 2⊠ F 97 Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, Y	1912 Virg	ginia				
and		Usual Residence of Decedent  10a. State	ocation			10d. Inside City Limits				
Mary f sho	ō	Maryland Frederick Mt. Airy				1 ∐Yes 2 X No				
the treatment	Director	Maryland Frederick Mt. Airy  10e. Street and Number	10f. Zip Code	100	J. Citizen of What Cou	intry?				
3a ol		6613 Jacks Court	21771		nited Stat	•				
death ms 2	Funeral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer					
after or ite		I 1 □ Never Married 2 □ Married I 1 □ Yes 2 🔀 No I		Rican, etc.)	Black, White					
ours E	d by	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 to No Specity:		Specify: Wh	ite				
72 h 'natu	Completed	(Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work	ing I	b. Kind of Business/I	ndustry				
vithin ene. <b>than</b>	dm	Elementary/Secondary (0-12)   College (1-4or 5+)	DO NOT use retired)	,	I C Nove					
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner is untited at	ပို	12 Secre		e (First, Middle, Ma	J.S. Navy	,				
d be 1 ental red o	) Be	George Willmath Wallace		e Bennett	,					
mark mati	၉		ng Address (Street and Number or Rur			in Code)				
nd 2 s llth ar 27 is r trau			Jacks Court, Mt.	· ·						
f Hearlife H		20a. Method of Disposition 20b. Place of Dispo	position (Name of matory or other place)  October		c. Location - City or T					
Page: ent o nt: if		1 △ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Fort Lincol	:	, I	entwood, Mar	vland				
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan D.partment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Experience is until be notified at orde.			2. Name and Address of Facility bert A. Pumphrey Funera							
Dermi Depa Impo any it			57 Wisconsin Avenue, Be			nase, mc.				
		23a. Part 1. Enter the disease, in complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.			, , , , , ,	Approximate				
Physician	R d	Immediate Cause (Final			1	Interval Between Onset and Death				
/Medical		disease or condition resulting in death)  a.   Where the condition of the				2 00 EE 12				
Examiner		Hypertons	Sequentially list conditions, b. Hypertons on Years							
. ± . α	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events								
ecute and trans	am	Cause (Disease or injury that initiated events c								
be ex cian ourial		Due to (or as a consequence of):								
Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Funeral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial-transit	dical	d								
leath certificat attending phy for use as the	/Me	IF FEMALE: 23c. If yes, outcome of pregnancy								
eath atter for u	cian	in the past 12 months?	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deli-	very Day Year				
at the de by the tached	Physician/Med	1 ☐ Yes 2 <b>AS</b> No 4 ☐ Pregnant at time of death 5 ☐ 9 ☐ Unknown								
res that signed b	by Pr	Part II. Other significant conditions contributing to death but not resulting in the u	nderlying cause given in Part I.	23e. Did toba	cco use contribute to	the cause of death?				
quire; an sig uld be	g p	Dementic		1 ☐ Yes	2 No 3 Pro	bably 4 Unknown				
s been si	Completed			24a. Was an	24b. Were aut	opsy findings available				
: The law icate has t , page 2 s	E			autopsy performe 1 ☐ Yes 2	prior to c	ompletion of cause of				
iclan: The certificate ector, pag	BeC	25. Was case referred to medical	26. Place of Deat	1 ∐Yes 2 M h (Check only one)	No 1 □ Yes	2 LI No				
nysic direc		examiner? 1 ☐ Yes 2 ☑ No	A.,		ce 6 ☐ Other (Spec	ifv)				
ng Pl	Certification: To	27. Magner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 1 Injury	-	28d. Describe how						
tendi leath. tor: A	cati	2 Accident Investigation	M 1 □Yes 2 □No							
or At after d Direct in by	Ħ	4 Homicide  4 Homicide  28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	et and Number or Rui State)	ral Route Number,				
pital ours a erai I		29a. Certifier 1. Certifying Physician: To the best of my knowledge, deat	the account of the time date and day							
To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certific completely filled in by the funeral director,	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.	nvestigation, in my opinion, death occur	red at the time, date	e and place, and due	stated. to the cause(s)				
To the within 2 To the Complet	Me	29b. Signature and title of certifier	29c. License number	29d	I. Date signed (Month)	, Day, Year)				
		Daneld Ciarlowll mg	334883		10/9/	2009				
lov	ŀ	30. Name and address of person who completed cause of death (Item 23a) (Type,	Print)		,					
Ψ'			eld Drive, #104, E	rederick	, Maryland	21701				
Stat			land of							
Registra	ar	OCT 09 2009 Serva B. A	harles							

09-07545 Diane Leech Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

Physicia		- For State Certificate of Death 1. Decedent's Name (First, Middle,Last)	Reg. 2. Date of Death Month	3. Time of De	1
ledical Examir		Diane H. Leech	September	27, 2009	5
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of D	eath	4c. County of Death  Montgomery	
		Mongtomery General Hospital  Olney  5. Social Security Number  16. Sex  7. Age (In yrs. last birthday)  If Under 1 Year  If Under 2	4Hrs 8 Date of Birth	(MM/DD/YYYY) 9. Birthplace (State	or
Funeral Director		219-46-7834 1 Months Days Hours	Min. April 1	Foreign	
any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside C	
Aaryland 28a-f show 1 at once.	5	Maryland Montgomery Rockville			2 <u>11</u> NO
th the Maryland 13a or 28a-f sho notified at once.	Director	106. Street and Number  106. Zip Code  20853		G. Citizen of What Country? United States	
th the 23a of notification	흹	7720 Oak Tree Road		14. Race - American Indian, Bl	ack,
ath wi	Funeral	1 Never Married 2 X Married Armed Forces? If Yes, specify Cuban, Mexican, Po		White, etc.	
fter de	린	3 Widowed 4 Divorced of Pales:  1 Yes 2 No 1 Yes 2 X No 1 Yes 2 X No specify:		Specify: White	
ours a	d by	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kinduring most of working life, DO NOT us		16b. Kind of Business/Industry	:
n 72 h	oleted	Elementary/Secondary (0-12) College (1-4 or 5+)		Own Home	1
-003 withingiene.	dmo	12	Name (First, Middle, M.		
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Everett Pugh Muri	el Hillier		
21. nould bed Mer is mar fic eve	후	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number			5.2
MD and 2 sho alth and 2 is 27 is 27 is		Robert D. Hogan/Husband 4428 Oak Tree Road  20a. Method of Disposition (Name of cemetery.)	ROCKV11 Date	1e, Maryland 2085 20c. Location - City or Town, State	-
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 X Cremation 3 Removal from State Montgoillery	October	·	
t. Pag tment rtant:	-	4 Donafion 5 Other Specify: a Crematorium, Inc.		Bethesda, Marylar	nd
Bal permi Depar Impo		House Montage Moloso 1300 West Montagery	Avenue Rock	ville, Maryland 20850	
Physician	$\neg$	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card failure. List only one cause on each line.	diac or respiratory arre	st, shock, or heart Approxima Between 0	ite Interval
dical caminer		Immediate Cause (Final disease a. Head and Torso Injuries		De	ath
tallifiel		or condition resulting in death)  Due to (or as a consequence of):			
	ē	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):			
	miner	Course Enter Underlying Cause (Disease or injury that initiated experts resulting in death) Lest  Due to (or as a consequence of):			
ansit	Exa	events resulting in death) Last  Due to (or as a consequence or).  d			
<b>Records, P.O. Box 68760,</b> The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial - transit	Medical	UNPENDED AMENDED			
760, cate b		IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the		23d. Date of delivery	Year
68 certifi nding	iä	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic past 12 months? 4 Pregnant at time of death 5 Other (Specify)	pregnancy	Month Day	1681
cords, P.O. Box 6876 law requires that the death certificate has been signed by the attending phy. 2 should be detached for use as the	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown			
P.O. es that the igned by t	by Pi	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		bacco use contribute to the cause of  2 ✓ No 3 Probably 4	
S, P uires ti n sign			24a. Was a		
ord w req as bee	Completed		autop perfor	sy prior to completion of	
	ĕ		1_Yes	2 ✓ No 1 Yes 2	No
tal Rec	Be	25. Was case referred to medical examiner?  Hospital: Inpatient 2 FR/Outpatient 3 DOA Other 4		Residence 6 Other:	
ion of Vital Records, tending Physician: The law require eath. or: After this certificate has been si the funeral director, page 2 should b	2	1 ✓ Yes 2 No	28d. Describe I	now injury occurred	
On C anding ath. r: Af he fun	tion	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury Sep 27, 2009 28b. Time of Injury 1650 hrs 1 Yes 2 ✔ I	No Subject stru	ck by falling tree	
Division tal or Attendi rs after death.	fica	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	. 28f. Location (5 or Town, S	Street and Number or Rural Route Nu	umber, City
Divisior  Hospital or Attend 24 hours after death Funeral Director:	Certification:	4 Homicide determined (Specify) driveway of residence	4428 Oaktree	Road, Rockville, MD	
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and place one)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.	ce, and due to the caus urred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)	
To the within 2 To the complet	/ed	and manner stated.  29b. Signature and title of certifier  29c. License number		29d. Date signed (Month, Day, Yea	ar)
	_	/// -		0 00 0000	
	_	O.C.M.E.		September 28, 2009	
• 11) V	V	30. Name and address of person who completed cause of death (Item 23a)		September 28, 2009	
-12 v	V	The prasell, "	, MD 21201	September 28, 2009	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 1:20 A M MCTAGGART OCTOBER 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner FOREST HILL HEALTH & REHAB CENTER HARFORD FOREST HILL Birthplace (State or Foreign Country)
 MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 10-27-1917 5. Social Security Number 6 Sev 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 ☐ M 2 💢 F 91 Director 216-05-4567 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show in than "natural", or Items 23a or 28a-f show MD 1 ☐ Yes 2X No Harford Director Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21009 USA 3215 Peverly Run Rd by Funeral hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ∐Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married altimore, Maryland 21215-0036 1 ∐Yes 27€No Specify: White 3X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry within 72 Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If Item 27 is marked other the any Injury or other traumatic event, 11th 2002. Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul Vigliato Jenny Salamone ೭ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John McTaggart (Son) 3215 Peverly Run Rd Abingdon MD 21009 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 10-08-2009 Timonium, MD 4 ☐ Donation 5 ☐ Other (Specify) Dulaney Valley 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licensee Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** center disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine use as the burial-trans and Due to (or as a consequence of): attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery The law requires that the death 3 Ectopic pregnancy Month Day Year signed by the ai Id be detached fo 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 0 2 🗌 No 3 Probably 4 Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? (es 2 2 No certificate 2500 1 □ Yes 1 ☐ Yes After this certification funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2√No Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Doth 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Spec/fy) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

P.O. Box 68760. Division of Vital Records, or Attending within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital

1 State

Registrar

Medical

D32275

BEL AIR, MD.

21014

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year) Oct 1 her 6, 2009

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

315 W. MACPHAIL LOAD

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

29a. Certifier

(Check only one)

DAVID DIINN

OCT 09 Zuus

32. Registrar's Signature

		•	State of Maryland / Dep	partment of Health and Nertificate of Death		ene 2009	32419	
			Decedent's Name (First, Middle, Last)		2. Date of Death		3. Time of Death	
н	Physicia /Medic		Efrain Lorenzo Molina		October	2,2009 Year	12:55A M	
la la	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death		
			Holly Hills Nursing Home	Towson		Balto.		
	Funeral Director		5. Social Security Number  052-10-5486  6. Sex 1 ☒ M 2 □ F  7. Age (In yrs. last birthda	// If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day April 26	,1917 Pue	hplace (State or Foreign unity) TTO Rico	
	pur .	}	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or	ocation			10d. Inside City Limits	
	faryli	ក	Md. Baltimore	Towson			1 □ Yes <b>X</b> □ No	
	28a-	ect	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	untry?	
	with be or	ā	531 Stevenson Lane	21286		USA	,	
	leath	era		Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ame		
Maryland 21215-0036	d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. It is marked other than "natural", or items 23s or 28s-f show traumatic event, the Medical Examiner round by notified at	by Funeral Director	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto  1  Yes 2 □ No Specify:	Rican, etc.)	Black, White Specify: Hi		
ŏ	2 hou	Completed		edent's Usual Occupation re kind of work done during most of work	1	6b. Kind of Business/	Industry	
212	thin 7	pie	(Specify only highest grade completed) (Gi Elementary/Secondary (0·12) College (1-4or 5+)	DO NOT use retired)	9			
7	e filed withing Hygiene. other than	Con		ding Service		A & E Vend	ing	
DG L	tal Hy	Be (	17. Father's Name (First, Middle, Last)		ne (First, Middle, M			
<del>y</del> la	2 should be f and Mental l le marked of raumatic eve	ို	Unknown		licia Mol		7.0.11	
Mar	12 sh h and 7 ie m		2 1	City or Town, State, 2 sylvania l				
	1 an Heal		Margaret Manning DTR.  20a Method of Disposition 20b. Place of Dis	position (Name of		20c. Location - City or		
Ğ	Pages nent of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	ematory or other place)	-2009	Balto. Md.		
Baltimore,	<sub>된</sub> 된 된 본 등		4 □Donation 5 □Other (Specify) Bayview  21. Signature of Funeral Service Licensee	Crematory   10-5		k Funeral	Home	
Ba	Depa Impo eny i		Lorge fle f	9705 Belair Rd.		ham, Md. 2		
			23a. Part1. Enter the disease, or complications that caused the death. Do not a shock, or heart lailure. List only one cause on each line.	inter the mode of dying, such as cardiac	or respiratory arre	est,	Approximate Interval Between	
	Physician		Immediate Cause (Final disease or condition	EROTIC C	arDlo	NASCUC	set and Death	
	/Medical		resulting in death)  a. Due to (or as a consequence of):			7176	SE	
Н	Examiner		Sequentially list conditions, b.					
	p #	iner	if any, leading to immediate Due to (or as a consequence or):					
8	ecute end -trans	Examiner	Cause (Disease or injury that initiated events c					
8760, 💢	cate be executed physicien end the burial-transit		Due to (or as a consequence or).					
687	physics the	G	d					
Box (	eath certific attending p	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death	B□Ectopic pregnancy		23d. Date of de Month	livery Day Year	
o.	of the dea by the ar	Physician/Medical	1   Yes 2   No 9   Unknown   Unknown	☐ Other (specify)				
rds, P	es the gned be de	ρ	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	A	accoluse contribute t s 2 □ No 3 □ P	o the cause of death?	
of Vital Records,	e law requir hes been si je 2 should i	Completed			24a. Was ar autops perform	24b. Were a prior to	utopsy findings available completion of cause of	
alF	Th page				1 ☐ Yes 2	Yes 1 ☐ Yes	2000	
<u> </u>	ici cer	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpat	Other :	th (Check only one			
<del>o</del>		. To	27. Manner of Death 28a. Date of Injury 28b. Time	of 28c. Injury at	28d. Describe ho	ince 6 Other (Special of the following occurred)	епу)	
on	Attending or death.	텵	1 (Month, Day Year) Injur 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No				
Division	i or Attendi efter death. Director: A d in by the fu	Certification;	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, larm, building, etc. (Specify)	street, lactory, office	281 Location (Sti City or Town	reet and Number or R n, State)	ural Route Number,	
_	To the Mospital or Atti within 24 hours efter de To the Funeral Direct completely filled in by the	edical Co	29a. Certifier  (Check only 2 Madical Examiner: On the basis of examination and/o					
	To the H within 24 To the F complete	Medi	one) and manner stated.  29b. Signature and title of certifier	29c. License number		9d. Date signed (Mon		
)	->		1 House 13. Cole	D 2 16.	80	10-8-	2009	
_	101,		30. Name and address of person who completed cause of death (Item 23a) (Tyl	ie, Printi)	rem	0_	-51512	
	Sta Regist		31. Date filed (Month, Day, Year) 32. Registrar's Signature	N.C. A				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 515 AM OCTOBER 7 2009 WILLIAM 4c. County of Death a, Facility Name (If not institution, give street and number) PLEASANT VIEW NULSING HOME 4101 OLD NATIONAL PILE 4b. City, Town, or Location of Death MANY AND C MOUNT CARROLL AIR If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 MM 2 □ F 79 373-28-8102 Yrs. <u>Únknown</u> Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 1 ☐ Yes 2 X No Carrol1 Mt. Airy 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21771 4101 Baltimore National Pike 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Given Year or Dates: 1 XNever Married 2 ☐ Married 1 ☐ Yes 2 ∏ No Specify Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Unknown Unknown Unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Unknown Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 125 Stoner Avenue, Westminster, MD 21157 Mrs. Gail Jones, Guardian 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Sykesville, MD Springfield Cemetery 10/9/2009 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Name and AIGHT Box Address of Facility FUNERAL HOME & CHAP 195 Sykesville, MD Hought MO0764 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Due to (or as a cor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or Due to (or 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 23e. Did tobacco use contribute to the cause of death?

**Physician** /Medical Examiner

**Physician** 

/Medical

Examiner

**Funeral** 

Director

ns 23a or 28a-f sl must be notified

"natural", or Items edical Examiner n

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Pages 1

Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event, i

Director

Funeral

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filed within 72 hours after death with the Maryland Hygiene.

Hygiene. "natural", or Items 23a or 28a-f show

Maryland 21215-0036

Baltimore,

P.O. Box  $68760_{\frac{1}{12}}^{C}$ 

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To the Hospital or within 24 hours aft To the Funeral Di

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Examiner Physician/Medical been signed by the should be detached þ Completed Be

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Certification:

Medical

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art II. Other significant condition	s contributing to death but not resulting is	n the underlying cause given in Par

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27. Manner 1 <b>⊠</b> Ñatu 2 ☐ Acc	latural	5 ☐ Pending investigation		ear)	28b. Time of Injury	M	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe how inj	ury occurred	
3 ☐ Suid 4 ☐ Hor		6 ☐ Could not be determined		- At ho Specif	ome, farm, stree	t, facto	ory, office		28f. Location (Street a City or Town, Sta	and Number or Rural Route Num te)	ber,
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26 Place of De

29a. Certifier Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state												
one) and manner stated												
29h Signature and	ttle of certifier	0				\	29c. License number	29d. Date signed (Month, D	y, Year)			

one)	and	manner st	red	\	1
9b. Signature and	ttle of certifier	Kar	Mark	29c. License number 0.6588	29d. Date signed (Month, Div, Year)

State Registrar

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death

25 Was case referred to medical

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month DP **Physician** SHIPLEY MARING **FRANCES** 2005 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Burtonsville Sanctuary at Holy Cross | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 08/23/1912 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Maryland 1 M 2 V F 97 214-16-6330 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatht and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov any injury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Savage Directo Maryland Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20763 U.S.A. 8731 Baltimore Street Funera 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∰No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXXNo Specify: White δ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Banking/ College (1-4or 5+) Elementary/Secondary (0-12) Laurel Building Assoc. President/Chairman of Board 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Francis Swan Lester Shipley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 8740 Baltimore Street Savage, Maryland Mary Anne Hall daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition \*\*Burlal 2 Cremation 3 Removal from State 11/10/2009 Arlington Nat. Cem. Arlington, 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M00770 Laurel, Maryland 20707 313 Talbott Avenue omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ly one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final THERUSCERO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Se quentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine that initiated events resulting in death) Last burial-trar the Hospital or Attending Physician: The law requires that the death certificate be execu Division or Vital Records, P.O. Box 68760, ₹ Due to (or as a consequence of): physician Physician/Medical the attending ph for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 5 Other (specify) 2 🗌 No signed by the a d be detached f 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of FIBRILLATION) 24a. Was an certificate has b irector, page 2 s autopsy performed? Yes 2 2 1 No 1⊟ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2 10 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P this : After this funeral of 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Certification: (Month, Day Year) Natural Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier elle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

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Registrar's So

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend # 6 per Fh g896 10/13/09 TT
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 200<sup>Year</sup> Month **Physician** October 9:08 AMMary Lucida Marton /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George Laurel Regional Hospital Laurel 9. Birthplace (State or Foreign Country)

Maryland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Year) 89 216-14-3310 May 4, 1920 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any linjury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1X Yes 2 No Director MD Prince George Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20707 U.S.A. 408 Prince George Street Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐Yes 2 ▼No Black, White, etc. 1 ∐Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🛛 No Specify چ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Customer Service Represent. Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Hopkins Genevieve Larkin ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Robert L. Marton / spouse 408 Prince George St., Laurel, Maryland 20707 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery Oct 12, 09 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service License M00773 313 Talbott Ave. Laurel, Maryland 20707-4389 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Fin I **Physician** Pulmonary Embolism disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Cholecystitis Sequentially list conditions, Due to for as a consequence of Examine If any leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed Pleural Effusion y physician and is the burial-trans Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending pt IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☒ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) ed by the 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ρ cate has been signated by page 2 should b Liver failure 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Sepsis autopsy performe certificate 1 ☐ Yes 2 🛛 No 1 Yes 2 No this certific 25. Was case referred to medical examiner? Be 26. Place of Death (Check onli one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2⊠No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ After this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. after death Director: A 2 Accident 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 🖸 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ca 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

7300 Van Dusen Road, Laurel, Maryland 20707

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

M.D.

Suresh Malik,

31. Date filed (Month, Day, Year)
OCT 0 9 2009

		State of Maryland  1 - State Registrar		rtment of He tificate of D			iene eg. No.	I, C	321.23
Physic	ian	1. Decedent's Name (First, Middle, Last)  Alberta Mae M	McCart	hv		2. Date of Deat Month October	Day 5, 20	Year 09	3. Time of Death 6:20 P M
/Med		4a. Facility Name (If not institution, give street and number)	Te our c	4b. City, Town, or I	Location of Death	00000	4c. County of Death		
Exami	ner	7163 Somerton Court		Hanover			Anne		
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Nov 13,	Year)		ace (State or Foreign ry) cinia
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exc. of them any injury or other traumatic event, the Medical Exc. of them must be mailfied and	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Yes 2 ☒ No If Yes, Give Year or Dates:		Yas Decedent of his Yes, specify Cubar	s Decedent of Hispanic Origin? (Specify Ye es, specify Cuban, Mexican, Puerto Rican, € ]Yes 2 🎇 No Specify:			ck, White, e	tc.
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VICA 12 sh th and 7 is n traun		19a. Informant's Name/Relationship (Type. Print)		Somerton					
Healt Healt em 2		Patricia M. Spencer /daughter  20a. Method of Disposition  20b. Pla	ace of Disnos	sition (Name of			20c. Location		
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BOX Bath cer attendir for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☒ No 9 □ Unknown  23c. if yes, outcome of pregnant 1 □ Live birth 2 □ Fetal (4 □ Pregnant at time of de 9 □ Unknown	death 3[	Ectopic pregnancy Other (specify)	y			ate of delive onth	ery Day Year
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On Of VItal Keding Physician: The Ing. After this certificate hat tuneral director, page	5 1	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time o	f 28c. Injur Worl	y at k?	28d. Describe h	now injury occu	rred	
VISION Attending If death. ector: Afte by the fune	atio	1 🕅 Natural 5 ☐ Pending (Month, Day, Tear) 2 ☐ Accident investigation			Yes 2 □ No				
DIVISION OT VIKAL RECORDS, if or Attending Physician: The law requires t after death.  Director: After this certificate has been signed in by the funeral director, page 2 should be early.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hor building, etc. (Specify	me, farm, str	reet, factory, office		28f. Location (8 City or Tov		nber or Run	al Route Number,
Hospita 24 hours Funeral tely fille	edical Ce		wledge, deat tion and/or ir	th occurred at the tinvestigation, in my c	me, date and place opinion, death occu	e, and due to the urred at the time,	cause(s) and r	manner as , and due t	stated. to the cause(s)
the lithin 2 the omple	Med	one) and manner stated.  29b. Signature and title of certifier \(\frac{1}{2}\)		29c. Licens	e number		29d. Date sign	ed (Month,	Day, Year)
<b>2</b> <sup>₹</sup> <b>2</b>		1 housens	AN	D243	34		Octobe	er 7.	2009
9		30. Name and address of person who completed cause of death (Item	23a) (Type.		J 1			_ , ,	
D		Thomas Finucane, M.D. 5505 H	opkins	s Bayview	Circle,	Baltimo	re, Mar	ylano	1 21224
	tate	31 Date filed (Month, Day, Year) 32, Registrar's Signat	ture						
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** Sep 11/142 We 5/ 30 2009 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give, street and number) Examiner moni 13ex 4619 Lesda Rosedale 1000001 If Under 1 Year | If Under 24 Hrs. 9. Firthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 🙀 M 2 🗆 F Yrs. 213-50-0554 Sept. 15. 1947 Washington, D.C. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the wadical Examinating at 1 ☐ Yes 2 No Director Maryland Bethesda Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number filed within 72 hours after death with 4619 Rosedale Avenue 20814 United States Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institutes Elementary/Secondary (0-12) College (1-4or 5+) Computer Programmer of Health Pages 1 and 2 should be filed v ment of Health and Mental Hygid ant: If Item 27 is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) James B. Maughlin Mary Virginia West 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mary B. Maughlin/Sister in Law 4518 Chase Avenue, Bethesda, Maryland 20b. Place of Disposition (Name of Gare of Heaven) October 17, 20c. Location - City or Town, State 20a. Method of Disposition 21. Signature of Funeral Service Licensee

Robert A. Fumphrey

MO0198

Part 1. Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Robert A. Fumphrey

Funeral Home/Bethesda-Chevy
Chase, Inc.

MO0198

Part 1. Her the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.

Approximate phock, or heart failure. List only one cause on each line. permit. Pages
Department of
Important: If It
any Injury or or X Burial 2 ☐ Cremation 3 ☐ Removal from State Immediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examine Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending p for use as IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 ☐ Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No certificate has been signed by the a rector, page 2 should be detached in 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 22 No 1 ☐ Yes 1 ☐ Yes 2 No 24 hours after death.

Funeral Director: After this certific letely filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier To the Hosp within 24 hou To the Funer completely fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number Signature and title of certifier MOPME

101

State Registrar TRN ~ BRECHER MD DME

31. Date filed (Month, Day, Year)

OCT 09 2009

32. Rigistrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Signature . Sand

Certificate of Death

1 - For State Registrar

			1. Decedent's Name (F	irst, Middle, Las	st)					2	2. Date of Dea Month		Vear	3. Time of D	Death
	Physici /Medio			K	irk Wesl	ey M	uller			C	ctober	5, 2	20 <b>0</b> 9ar	9:47	$A^{M}$
_	Examir		4a. Facility Name (If no	t institution, giv	e street and numbe	r)		4b. City, Town, o	r Location	of Death		4c. Cou	nty of Death	1	
at .			10921 Inwo					Silver					tgome	-	
	Funeral Director		5. Social Security Numb 214-48-812		ex 7.7 XIM 2□F	Age (In yrs. 1	last birthday Yrs.	Months Days	Hours Hours	Min. A	B. Date of Birth (Month, Day pril 24	, Year) 1945	Col	hplace (State or untry) ington, D.	
	P.		Usual Residence of Dec			1								101 1 111 011	. 1 ''
	show	<u>_</u>		b. County		10c. Cit	y, Town or L							10d. Inside City	
	he Ma	Directo		Montgom	ery		Silve	er Spring				10g. Citizen	of Mhat Car		
	with t		10e. Street and Number		nuo #330			10f. Zip Code	906			Unite		-	
	leath	Funeral	10921 TIIW	Jou Ave	12. Was Deceder	nt Ever in U.	S. 13.	Was Decedent of H		rigin? (Spec	ify Yes or No-			rican Indian,	
9	or iter		1 X Never Married	2 Married	Armed Forces 1 ☐ Yes 2 2	§? ¶No					ican, etc.)		Black, White		
93	72 hours after death with the Maryland natural", or items 23a or 28a-f show digal Examinar must be notified at	d by	3 ☐ Widowed 4 ☐	Divorced	If Yes, Give Year or Dates	s:		1 ☐ Yes 2 X No	Specify	:		Spe	cify: W	hite	
21215-0036	be filed within 72 hours after death with the Marylan ital Hygiene.  do other than "natural", or items 23a or 28a-f show event, the Medical Examinational Examination In the Medical Examination In the Medical Examination In the Medical Inc.	Completed	15. (Specify o	Decedent's Econly highest gra	ducation de completed)		16a. Dece (Give	edent's Usual Occup e kind of work done DO NOT use retired	oation during mos	st of working	,	16b. Kind of		-	
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lan	should be f and Mental s marked o umatic eve	To Be	Harry G.	Muller,	Jr.				E	Evelyn	Kidwe	dwell			
ary	l and 2 s Health ar sm 27 is ther trau	-	19a. Informant's Name				19b. Mail	ng Address (Street	and Numb	er or Rural	or or Rural Route Number, City or Town, State, Zip Code)				
Ξ			Christine	M. Pul:	ford /Sis	ter	16916	01d Sawr	nill 1	Road,	Woodbi	ne, Ma	nd 21797	7	
altimore, Maryland			20a. Method of Disposit		Domoval from Stat		Place of Disp cemetery, cre	osition (Name of matory or other place	ce) (	Octobe	r 8,	20c. Location	on - City or T	Fown, State	
Ë	nit. Pag vartment ortant: I Injury c		4 □ Donation 5 □			Mon	tgomery	Crematorium	n, Ind	2009		Bethes	da, M	lary1and	
Ball	permit. Pages 1 Department of P Important: If ite any Injury or of once.		21. Signature of Funer	al Service Licer	1800	M013	OF RO	2. Name and Addre	ess of Facili nphrey	<sup>ity</sup> Funera	1 Home/F	Rockvill	le, Inc		
	TO 2 8 0	_	(Myerel	at Kypul	W.		03 30	00 West Mont	gomery	Avenu	e, Rockv	ille, M	larylan	d 20850-2 Approximate	
			23a. Part 1. Fater the d shock, or heart fa Immediate Cause (Fina	illure. List only	one cause on each	line.	n. Do not er	iter the mode of dyl	ng, such as	s cardiac or	respiratory an	rest,		Interval Betw Onset and D	veen
	Physician /Medical		disease or condition resulting in death)	ai	a	redema								Years	
The same	Examiner				Due to (or a	as a consequ	uence of):								
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ó,	e exe sian a urial-t		resulting in death) Last		Due to (or a	as a consequ	uence of):								
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Вох	atter for u	cian	23b. Was decedent pre in the past 12 mor	nths?	1 ☐ Live birth 4 ☐ Pregnan	2 Feta	I death 3	☐ Ectopic pregnand ☐ Other (specify) _	СУ			230.	Date of deli Month	•	'ear
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ų.	or Attending Physician: The law requires that the death certificate be executed ther death.  Director: After this certificate has been signed by the attending physician and in by the funeral director, page 2 should be detached for use as the burial-transit.	by P	Part II. Other significar	nt conditions o	ontributing to death	but not res	ulting in the	underlying cause giv	en in Part	l.	23e. Did to	bacco use c	ontribute to	the cause of de	eath?
ğ	w require been signature should b										1 □ Y	es 2🛣 N	o 3 □ Pr	robably 4 □ U	nknowi
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= B	The law cate has	Som									perfor 1 ☐ Yes	med?	death?	2 □No	
/ita	slcian: T certificat rector, pa	Be	25. Was case referred examiner?	to medical	Lie e-itali			1011		e of Death	(Check only or	ne)			
of Vital Records,	Physical direction	<u>ا</u>	1 No Yes 2 No		Hospital: 1 ☐ Inpa 28a. Date of I		ER/Outpatie	III 3LI DOA			e 5 🛛 Resid			cify)	
U	ding h. After funer	tion		Pending investigation	(Month, i	Day, Year)	Injury	Wor	rk? ]Yes 2.⊑		8d. Describe h	ow injury oc	curred		
Division	Attendi death. cctor: A	fica		Could not be	e 28e. Place of	njury - At ho	ome, farm, s	reet, factory, office	1103 EE		Bf. Location (S	treet and Nu	ımber or Ru	urel Route Numb	ber,
S	al or after	Certification:	4  Homicide	determined	building,	etc. (Specif	<i>(y)</i>				City or Tow	n, State)			
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical C				of examina		th occurred at the t							
	o the	Mec	29b. Signature and title	of certifier	and manner	stateu.		29c. Licens	se number			29d. Date sig	ned (Monti	h, Day, Year)	
	->-0			P	era 1	u.D	١	DS	067	18		10/6/	2009		
	91		30. Name and address	of person who	completed cause o	f death (Iten	n 23a) (Type	, Print)				. /			
	l		Rajeev Ba					nire Aven	ue, #	300,	Silver	Sprin	g, Ma	ryland 2	2090
	Sta Regista		31. Date filed (Month, L		ann K	tian's Signa		hall							
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Lida Ruth Marchiano 9:55 P M 2009 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Gilchrist Hospice Center Towson Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Country)
Maryland Director 65 218-40-7059 Nov. Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Dundalk 1 Yes 2 No Baltimore Maryland 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21222 842 Mildred Avenue th and Mental Hygiene. 27 is marked other than "natural", or items traumatic event, the Medical Examiner mu Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces' Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2√√No Specify: 3 Widowed 4 Divorced Year or Dates White Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home 10 Years Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Unkn. ဂ Ruth John Fitzpatrick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9003 Harford Road Parkville, Maryland 21234 Mr. Philip Schruefer (Son) or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of F
Important: If ite
any injury or ot 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State cemetery, crematory or other place; Hilltop Service Corp. 10/9/2009 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu uneral Serv Duda-Ruck Funeral Home of 7922 Wise Ave. Dundalk, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as A consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ng physician and as the burial-transit Cause (Disease or impury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) \_\_\_\_ for in the past 12 months?

1 Yes 2 No Month Pregnant at time of death detached the 9 Unknown 9 Unknown completed filled in by the funeral director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Orthodive pulmoron Completed 1 Yes 2 □ No 3 □ Probably 4 □ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? within 24 hours after death.

To the Funeral Director: After this certificate 2 🗌 No 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify မ 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at Natural 28d. Describe how injury occurred 5 Pending work? 2 🗌 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year) 2009

2. Registrar's Sign

			se Type or State o						II Copies		ible.		
	•	for State Registrar		, maryian		tificate d					119	32427	
Physicia	an	1. Decedent's Name (First, Middle	. ,						2. Date of Deat Month		Year	3. Time of Death	
/Medic			Machado						October			8:45AM <sup>M</sup>	
Examin	er	4a. Facility Name (If not institution 9506 49th Av	enue			4b. City, Tow Co1	lege I	ark		Pr		George's	
Funeral Director		5. Social Security Number 101–52–3909	6. Sex 1 □ M 2√2 F	7. Age (In yrs. 51	last birthday) Yrs.		ays Hours	er 24 Hrs. Min.	8. Date of Birth (Month, Day, Augt. 11	,1958	Cou	place (State or Foreign intry) York	
ryland how		Usual Residence of Decedent  10a. State 10b. County			ty, Town or Loc							10d. Inside City Limits	
Ra-fs	Director		e George'	S		Colleg						1 X Yes 2 □ No	
with the	Dir	10e. Street and Number 9506 49th Avent	ıe			10f. Zip Co	de 2074	0	1	10g. Citizen of What Country? United States			
death	Funeral	11. Marital Status		edent Ever in U	.S. 13. V	Vas Decedent	of Hispanic (	Origin? (Sp	pecify Yes or No- p Rican, etc.)	14. Ra	ice - Ameri	ican Indian,	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic event, the Medical Examination and Injury or other traumatic events.	þ	1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 🎇 Divorced	Armed Formed Fo	2 (ŽNo ive					rto Rican		ick, White,	spanic	
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nd 2 sh alth and 27 is rr er traum		19a. Informant's Name/Relationsl Joshua Berrios							ral Route Numbel ege Park	•	n, State, Zi 2074	_	
ages 1 a ent of He it: If item y or othe		20a. Method of Disposition  1 ☐ Burial 2 【X Cremation  4 ☐ Donation 5 ☐ Other (S)		State	Place of Dispos cemetery, crem esapeak		i		ober 8	20c. Location	-		
permit. F Departme Importar any Injur		21. Signature of Funeral Service		M0030					Oremation			e, MD	
88 = 88		July 2	tolama	m	9	33 Gis	t Ave.	, Si	lver Spr	ing, MI	20	910	
Physician		23a. Part 1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	-					est,	- 2	Approximate Interval Between Onset and Death	
/Medical		disease or condition resulting in death)		ASTATIO		the ce	il Cr	1KC11	Nomm			13 MON745	
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To the Hospital or Attendi within 24 hours after death. To the Funeral Director: /	edical	29a. Certifier 1 Certifyin (Check only one)	g Physician: To the Examiner: On the l and mar	e best of my kno pasis of examina nner stated.	owledge, death ation and/or inv	occurred at the vestigation, in	he time, date my opinion, o	and place leath occu	e, and due to the or rred at the time, or	ause(s) and r late and place	manner as e, and due	stated. to the cause(s)	
To t	M	29b. Signature and title of certifier	14	0 11	1	29c. Lio	cense numbe	r	2	9d. Date sign	ed (Month	, Day, Year)	
	-	30. Name and address of person	who completed cau	se of death (Iter	n 23a) (Type, F	Print)	516	ا لو		10	- (	208/5	
V		NELSON GUSTAG	10 NEDER	KALIL	MD 5	5454W	ISCON	SINI	AUE#130	U BE	THES	DA MO	
Sta	te	31. Date filed (Month, Day, Year)	32.	Registrar's Signa	ature								

DHMH 17 Rev 1/2001

Registrar

OCT 0 9 2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 6, Day 2009 Year Loretta McAdams 12:55 PM Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Gilchrist Hospice Baltimore Towson Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🕅 F Months Days Hours Min. FEb 20 Maryland 219-40-1155 Director Ĩ′943 66 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director MD 1 Yes 2 No Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3808 W. Garrison Avenue 21215 USA 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify. white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation unk unk 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) unk Be permit, Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Hugh Fuller Doris Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gilchrist Hospice 555 W. Towsontown Blvd Towson, MD or other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place injury 4 Donation 5 Other (Specify) 21. Signature of Euneral Se ROPA State Anatomy Board 655 W. Baltimore Street Raltimore MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition Onset and Death Physician/ Acure elogenous my months Medical resulting in death) Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) and I-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): burial inding physician ause as the burial. Physician/Medical Box 68760 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months?

1 Yes 2 No jo Year Pregnant at time of death Month Day signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 autopsy death? this certificate 2 No \_l Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending of Funeral Director: Ail leted filled in by the fu Accident 1 Tes 2 No Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined

P.O. Division of Vital Records, within 24 hor To the Fune completed fi

> 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) thison mo State Registrar

Medical

29a. Certifier

only one) 29b. Signature

3 □

ad title of certifie

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

ocrosser 6 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** John Morgan Mattingly, October 6, 2009 Jr. 10:16 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Pickersgill Towson Baltimore Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days M 2□ F 89 Oct. 10, 1919 Director Maryland 219-07-1761 Usual Residence of Decedent s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural" or items 23s or 20s to 10 constant 10d. Inside City Limits 10c City Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Towson 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 615 Chestnut Avenue 21204 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. event, the Medical Examiner 1 Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🔀 No Specify: Specify: Be Completed by 3 ₩ Widowed 4 Divorced White 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4 years Builder Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John Morgan Mattingly, Sr. ٩ Mary Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other traum once. Barbara M. Wilson (daughter) 1110½ Mitchell Street Annapolis, Maryland 21403 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 10-8-09 Green Mount Crematory Baltimore, Maryland 22. Name and Address of Facility
Mitchell-Wiedefeld Funeral Home, Inc.
6500 York Road Baltimore, Maryland Signature of Funeral Service/License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death obstructive Lung disense Immediate Cause (Final Wronic ears **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. or Vital Records. þ heart failure 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) P 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: (Month, Day Year) 1 Naturai Injury 5 Pending within 24 hours after con-1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) October 7, 2009 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Jem 23a) (Type, Print) 6701 N. Charles St. Balto. Mb Zizox

Registrar

State

31. Date filed (Month, Day, Year)

Baltimore. Maryland 21215-0036

Box 68760.

P.O.

Division

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#16aperFH, G896, 1079709, WS
State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/  $\mathbf{P}^{\,\mathsf{M}}$ October 06 2009 1:53 **Beatrice** Medical Newmuis 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner Paltimore** Gilchrist Center For Hospice Care Towson 7. Age (In yrs. last birthday) 65 Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 M 2 F Days 219-40-5000 MARY/AND Director Usual Residence of Decedent items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland or other traumatic event, the Medical Examiner must be notified at Completed by Funeral Director BALTIMORE 10f. Zip Code 1 Yes 2 ☐ No MD 10e. Street and Number 10g. Citizen of What Country? CATON U.S.A. 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☐ No Black, White, etc. ò 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: BLACK "natural", 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) SALES Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be filk Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve မ BUCKNER HERMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

826 HÖIIINS St. Apt # 2, BALTIMER & B 19a. Informant's Name/Relationship (Type, Print) SON IANT NEWMUIS 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1. Burial 2 Cremation 3 Removal from State 12/2009 LANSCLOWNE MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility The DEARICK C. SONRS E/H, P.A. Signature of Funeral Service Licensee PARK HGFS. Ave., BALTIMORE, Med. 21215 23a. Part 1. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caus in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innertal director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ legs, periphnal vasular Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Rephrosdowsin 24a. Was an autopsy performed? Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🙀 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred 1 🔀 Natural injury 5 Pending Investigation Accident 3 ☐ Sulcide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) OCTOBER 6 200 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W N Charles Si 670 Hours

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

2009

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2000

		For State Registrar	State of	f Marylan	-	artment of I <i>rtificate of</i>		d Mental Hy	giene Reg. No. 2	]119	32431
Physicia /Medio		1. Decedent's Name (First, Middle RETCH	1	/	11	EVE	5	2. Date of De Month	ath Day O(	Year 09	3. Time of Death 2 30 4 M
Examin		4a. Facility Name (If not institution	n, give street and nur			4b. City, Town, o	or Location of D	eath		y of Death	7.7
		Hospice of the 5. Social Security Number	_	7. Age (In yrs.		Linthi If Under 1 Year		Hrs. 8. Date of Bir		ne Aru	
Funeral Director		577-66-3746	1□ M 2□ F	59	Yrs.	Months Days		Min. (Month, Da 11/5/1	ıy, Year)		place (State or Foreign ntry) 1and
pu.		Usual Residence of Decedent		10. 0	. T			1 22/ 3/ 2			0d. Inside City Limits
f show	ō	10a. State 10b. County	77-7		y, Town or Lo	cation				'	1 ☐ Yes 2 ☑ No
the N	rect	MD Anne  10e. Street and Number	Arundel	Cro	ofton	10f, Zip Code			10g. Citizen of	What Cour	itry?
h with 23a or	al Di	1690 Albamarle	Drive			21114	1		_	.S.A.	,
r deat	Funeral Director	11. Marital Status	12. Was Dece Armed Fo	edent Ever in U.	S. 13. \	Nas Decedent of I	Hispanic Origin'	? (Specify Yes or No uerto Rican, etc.)	14. Ra	ce - Americ	
s afte	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🖫 Divorced	ried 1 ∏Yes If Yes, Giv	2 ⊠ No ve		I∐Yes 2⊠No		, , , , , , , , , , , , , , , , , , , ,	Speci		nite
be filed within 72 hours after death with the Maryland the Hydiene. I have the "Marural", or items 23a or 28a-f show event, I're Madrel Everning must be notified at			Year or Date  t's Education st grade completed)	ates:	16a. Deced	dent's Usual Occu	pation		16b. Kind of E		
thin 7;	Completed	(Specify only higher Elementary/Secondary (0-12)	St grade completed) College (1	-4or 5+)	(Give life. l	kind of work done OO NOT use retire	during most of ed)	working			
yidilid 212  buld be filed withi Mental Hygiene. arked other thar atic event, Ire In		12	(apt)		Dent	al Assi	stant	Name of Cinet Adiabate	Med i		
direction of the control of the cont	) Be	17. Father's Name (First, Middle, William	Lasi)			Casler	Mary	Name (First, Middle,	Agnes	me)	French
and Men is marke aumatic	ဥ	19a. Informant's Name/Relations	hip (Type. Print)				- 4	r Pr Rural Route Numbe	,	ı, State, Zir	
tra tra		Mary Denise Hir	es/ Siste	r	3530	Arters M	Mill Roa	ad, Westmi	nster,	MD 21	158
ges 1 t of He or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐ Removal from	20b. P	lace of Dispo emetery, cren	sition (Name of natory or other pla		Date	20c. Location	-	
Dealth Indiana Pages Separtment of mportant: If it in injury or one of the control of the contro		4 ☑ Donation 5 ☐ Other (S	pecify)	Ana		fts Regist		0/8/2009			ryland
partition e, permit. Pages 1 and Department of Heal Important: If item 2 any injury or other once.	. 1	21. Signature of Funeral Service	Ligensee					Anatomy Gi Dr.,Ste.P,			
		23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that c	aused the death			-				Approximate Interval Between
Physician		Immediate Cause (Final disease or condition	only one cause on e	Ends	taxu	COP	D				Onset and Death
► /Medical Examiner		resulting in death)	Due to (	or as a consequ	uence of):		,				
	-e	Sequentially list conditions, if any leading to immediate	b	or as a consequ	uence of):						
cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events									
be exection and cian an aurial-tr		resulting in death) Last	Due to (	or as a consequ	uence of):						
ate hysi	edical		d								
o se di c		IF FEMALE:	23c. If yes, out	come of pregna	incv				22d D	ate of delive	
death e atter	iciar	23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No	1 ☐ Live b 4 ☐ Pregr	oirth 2  Fetal nant at time of d	death 3	Ectopic pregnan Other <i>(specify)</i>	cy			lonth	Day Year
that the de ned by the a	Physician/M	9 ☐ Unknown	9 ☐ Unkn	70.00							
res thi	ğ	Part II. Other significant condition	ns contributing to de	eath but not resu	ulting in the ur	nderlying pause gi	ven in Part I.				ne cause of death?
w requir	Completed		8 10	(0)00	V 00		-7	_ 12			pably 4 Unknown
he law e has ige 2 s	Jdmo		<del></del>					— 24a. Was autor perfo			psy findings available mpletion of cause of
an: T	Be Co	25. Was case referred to medical					26 Place of	1 ☐ Yes Death (Check only o	2 No	1 🗆 Yes	2 No
Physician: The le rthis certificate ha	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 □ I	npatient 2	ER/Outpatien	t 3 DOA Ott	hor:	ng Home 5 ☐ Resid		ther (Specif	4 BICNICE
ding Ph h. After th funeral	ion:	27. Manner of Death  1 Natural 5 Pendin	9 1 '	of Injury h, Day, Year)	28b. Time of Injury	Wo	rk?	28d. Describe	how injury occu	rred	HOUSE
or Attending Physician: The law requires that the death cer Dorac death.  Director: After this certificate has been signed by the attending in by the funeral director, page 2 should be detached for use	ficat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could i	not be 390 Place	of Injury - At ho	me farm stre	M 1 Deet, factory, office	]Yes 2□No	28f Location (	Street and Num	ther or Pur	al Route Number,
al or A	Certification:	4 ☐ Homicide determ	ned buildir	ng, etc. (Specify	y) , ram, str	oct, lactory, office		City or Tov	wn, State)	Del Ol Fible	ii riodle Namber,
To the Hospital or Attendin within 24 hours after death To the Funeral Director: Aft completely filled in by the fur.	edical (		g Physician: To the Examiner: On the ba and man								
To th within To th comp	Me	29b Signature and title of certifier	120	1		29c. Licen	se number	2.6	29d. Date sign	ed (Month,	Day, Year)
		TONCO	500	W7210	<b>~</b>		114	38	let	ohn	02,2009
		30. Name and address of person	Who completed caus	- VM \	L Z3a) (Type	EYE NS	EH	6 H WAY	(two	JARVIS	MAZIYU

State Registrar

OCT.0 9 2009

31. Date filed (Month, Day, Year)

32. Registrar's Signature

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Maryland	•	ortment of H			giene Reg. No. 20	1,9	32430
ľ	Physici	an	Decedent's Name (First, Middle, Last)     James Gerard Oakle	277				2. Date of Dea	nth Day	,	Time of Death
	/Medio		4a. Facility Name (If not institution, give s	-		4b. City. Town, or	Location of Dea	th OCV	5 21 4c. County of		2,271
*	Examin	er	Sanctuary at Holy	,		Burtons	ville		Montgo	mery	
	Funeral Director	Ų.	5. Social Security Number 6. Sex	7. Age (In yrs. la	a <i>st birthday)</i> 19 Yrs.	If Under 1 Year Months Days	If Under 24 Hr Hours Mir		, Year) 2, 1960	9. Birthplace Country)	e (State or Foreign DC
	and w		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	cation				10d.	Inside City Limits
	Maryl I-f sho fied al	tor	MD Prince Ge	eorge Laur	cel						1 ∐Yes 2 <b>%</b> No
	th the or 28a e noti	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of Wh	nat Country?	
	ath w	ral	8820 Hunting Lane			20708			USA	A	- 4:
30	be filed within 72 hours after death with the Maryland that Hygiene.  dother than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Funeral	11. Marital Status  1X∑Never Married 2 ☐ Married  3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U.\$ Armed Forces? 1 ☐ Yes ② Mo If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I □ Yes	spanic Origin? ( n, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)	Black, Specify:	American I White, etc. whit	
12-0036	2 hour atural cal Ex		15. Decedent's Educ	cation	16a. Dece	lent's Usual Occupa	ation		16b. Kind of Busi		ry
1213	within 72 iene. than "n the Medl	Completed	(Specify only highest grade Elementary/Secondary (0-12) 12	College (1-4or 5+)		kind of work done of DO NOT use retired Specialis		orking	Informa Technol		
land	tal d o	To Be Co	17. Father's Name (First, Middle, Last) Donald L. Oakley					ame (First, Middle, lizabeth		)	
Mary	ges 1 and 2 should it of Health and Mer If Item 27 is marke or other traumatic		19a. Informant's Name/Relationship (Ty) Mary C. Gambo/ Si	*	1	ng Address <i>(Street &amp;</i> Dolphin S					*
ore,	es 1 a of Heg		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ R		lace of Dispo emetery, crei	sition (Name of matory or other plac	(e) OC	Date tober 8,	20c. Location - C	ity or Town,	State
Saitimor	t. Pag tment tant: I	. 1	4 ☐ Donation 5 ☐ Other (Specify)	Gat		Heaven Ce	m.	2009	Silver S		
pa	permit. Pages 1 and Department of Healt Important: If Item 2: any injury or other once.		21. Signature of Funeral Service License	M010	053 3	2. Name and Addres	t Ave.,	Laurel,	MD 20707	7	
	Physician /Medical	0. 7	23a. Parti. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused the death lie cause on each line.  Due to (or as a consequ	· Co	er the mode of dyin		_	rest,	Ap Int Or	proximate lerval Between nset and Death
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8/00, g	death certificate be executed e attending physician and d for use as the burial-transit	II Examin	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequ	uence of):						
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ν. Τ	requires that the een signed by th nould be detache	by Ph	Part II. Other significant conditions cor					_	obacco use contrib	oute to the c	ause of death?
cords	equire en sig ould b	ted b	CHRONIC OBS	TRUCTIVE /	ulmo	NARREP	DISEA	101	res 2 No 3	3 ☐ Probabl	y 4 Donknown
T T	The lar ate has page 2	Completed						24a. Was autop	psy pr rmed2 de	ior to comple eath?	findings available etion of cause of
VIII	ician: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?	In an Note		l ou		eath (Check only o	ne)		
	di is	٦.	1 Yes 2 No	lospital: 1 ☐ Inpatient 2 ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	ER/Outpatier 28b. Time o		Nursing	Home 5 ☐ Resid	dence 6 Other		
VISION	nding th. : After e funei	tion	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury	Worl	yat k? Yes 2∐No	Zou. Describe i	low injury occurre	u	
DIVIS	al or Atter after dea I Director d in by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office	10.	28f. Location (S City or Tou	Street and Number vn, State)	r or Rural R	oute Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical C		isician: To the best of my knowner: On the basis of examinational and manner stated.							
	To th within To th comp	Me	29b. Signature and title of certifier	<i>P</i> .		29c. License		1	29d. Date signed		
A			Jasneeu 5	Lalhani	nn)	D28	-95		10/6/0	5	
	5		30. Name and address of person who co	KHANI, Mis	2936	Print) Smitt	H AVE	SUITE	203, f.	DAED 1	MD 21275
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture	2					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ October 8. 2009<sup>Year</sup> Jennie Catherine Ptasinski 9:12 РМ Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Stella Maris Timonium 5. Social Security Number 6. Sex **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Days Hours 69-14-5342 1 □ M 2 🛛 F 12726/1919 Pennsylvania **Director** Yrs. 89 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Middle River 1 🗌 Yes 2🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1404 2nd Road 21220 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force 1 ☐ Yes 2 🛣 No If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after ment of Health and Mental Hygiene. 1 Yes 2XXNo Specify: Completed Specify: White 3 X Widowed 4 Divorced Year or Dates other than "natur 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Maryland 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental H Important: If item 27 is marked ott any injury or other traumatic even 18. Mother's Name (First, Middle, Maiden Surname) John Paczkowski Josephine Korzeniewska 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Rose M. Smith (Daughter) 1709 Woodhome Drive, Bel Air, Maryland 21015 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Newport Township Date 1 🛭 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Trinity Cemetery 10/12/2009 Penńsylvania 22. Name and Address of Facility Bruzdzinski Funeral Home P.A. 1407 Old Fastern Avenue Essex, 21. Signature Maryland 21221 23a. Cart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph\_sician/ disease or condition DEMENTIA Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine cause. Enter Underlying To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burnar-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) \_\_\_\_ 1 ☐ Live Birth 2 ☐ Fetal deat 4 ☐ Pregnant at time of death 9 ☐ Unknown in the past 12 months?

1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsv 1 ☐ Yes 2 ☐ No of Vital 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2X No 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? 1 X Natural Accident 5 Pending iniury Division 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State)

CTOBER

JENNIE

State Registrar

Medical

29a. Certifier

(Check

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM, MD 21093

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year) 9/2009

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death October 200<sup>Year</sup> Beverly Jean Poisal 8:12a 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Carroll Carroll Hospital Center Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Nov 19 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Months Days Hours 1 □ M 2 💢 F 75 213-30-5360 Nov 1933 Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits Carrol1 Eldersburg 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21784 USA 6218 Rolling View Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify: White Specify 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore Co. Courts psychologist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles Reyeur Viola Lindstrom 19a. Informant's Name/Relationship (Type. Print) Steven G. Poisal (son) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 56 Berkshire Ct., Westminster, MD 21158

**Physician** /Medical

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**Physician** 

/Medical

**Examiner** 

10a. State

Director

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**Funeral** 

Director

s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Marical Expression rust be notified at

Examiner

Examine attending physician and for use as the burial-transi Physician/Medical cate has been signed by page 2 should be detach Completed by Be Certification: To I hours after death.
uneral Director: Af

Division of Vital Records, P.O. Box 68760 %

or Attending Physician:

within 24 hours a

Medical

20a. Method of Disposition		20b. Place of D	20b. Place of Disposition (Name of cemetery, crematory or other place)			Date 20c. Location - City or Town			Town, State	
1			iew Memo		10-13	-09	Syke	esville	, MD	
21. Signature of Funeral Service Licer	nsee		22. Name and	Address of Fa	acility Haig	ght Fun	iera]	l Home	& Chapel	_
Daige Jaigh	t Herbert		P.O. Bo	x 195	Sykesv	ille, M	ID 21	1784		
23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plications that caused the								Approximate Interval Between	
Immediate Cause (Final disease or condition resulting in death)	a. Aa	NE M	Ayrea	rdia	110	farc	hio	ら	Onset and Death	
	Due to (or as a	consequence of)								
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	oursequence of)								
resulting in death) Last	Due to (or as a	consequence of)								
	d									_
IF FEMALE:     23b. Was decedent pregnant in the past 12 months?     23c. If yes, outcome of pregnancy     23d. Date of delivery       1 ☐ Yes     2 ☐ No 9 ☐ Unknown     4 ☐ Pregnant at time of death of dea										
Part II. Other significant conditions of	ontributing to death but	not resulting in th	ne underlying cau	se given in Pa	art I.	23e. Did to	obacco u	use contribute t	o the cause of death?	
Citt						1 □ Y	/es 2	□No 3□P	robably 4 Unknow	wn
tema	nent f	neem	akev			24a. Was		24b. Were a	utopsy findings availat	ble
							rmed? 2 No	death?		и
25. Was case referred to medical examiner?				26. P	lace of Death	(Check only o	ne)			
1 ☐ Yes 2 ☐ Mo	Hospital: 1 ☐ Impatient	2 ER/Outpa	atient 3 DOA	Other: 4 🗆	Nursing Hom	ne 5 🗆 Resid	dence	6 ☐Other (Spe	ecify)	
27. Mann f Death 1 atural 5 Pending 2 Accident investigation		Year) 28b. Tim Inju		injury at Work? 1 ∐Yes 2		8d. Describe h	now injur	y occurred		
3 Suicide 6 Could not be determined	28e. Place of Injury building, etc.	/ - At home, farm (Specify)	, street, factory, o	office	2	8f. Location (S City or Ton	Street an vn, State	nd Number or R e)	lural Route Number,	
29a. Certifier 1	ysician: To the best of niner: On the basis of e and manner state	xamination and/	death occurred at or investigation, i	the time, dat n my opinion,	e and place, a death occurre	and due to the ed at the time,	cause(s date and	) and manner a d place, and du	as stated. e to the cause(s)	
29b. Signature and title of certifier	7			icense numb	1 13		29d. Da	te signed (Mon	th, Day, Year)	
16 1 1 Andr	m		0	3950:	2 Miles		10	18/09		

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year) 32. Registrar's Signature

he and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend item 19b per fh g896 10-9-09 vt State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 391.35 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT of ar 13.414 Sara  $\tilde{0}7$ 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death The Johns Hopkins Hospital Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec, 2, 1941 Birthplace (State or Foreign Country) Age (In yrs. last birthday) 1 - M 2 XF Months 210-32-9809 Pennsylvania 67 Usual Residence of Decedent 10h. County 10c. City, Town or Location 10d. Inside City Limits Chester 1x Yes 2 □ No Morris 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 07930 USA 2 Twin Brooks Trail 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married 1 Yes No If Yes, Give Year or Dates; 1 ☐ Yes 2X No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) Education Professor Emeritus 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Viola Sweigart Cyrus Beekey 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Twin Brooks Trail-Chester Pennsylvania, 07930 Peter A. Pfaffenroth-spouse 20b. Place of Disposition (Name of Cemetery, crematory or other place Mt. Hope Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State Oct.12,2009 Myerstown, Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Evans Funeral Chapel and Cremation Services 8800 Harford Road-Parkville, Maryland 21234 15 endral 47 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between

**Physician** /Medical Examiner

**Physician** 

/Medical

**Examiner** 

10a. State

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To the Hospital or Attending Physiclan: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

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that initiated events resulting in death) Last	Due to (or as a consequence of):				
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	ntributing to death but not resulting in the unc	derlying cause given in Part I.		use contribute to t	
	·		24a. Was an autopsy performed?	prior to co death?	psy findings available mpletion of cause of
25. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)		
	lospital: 1 Inpatient 2 ER/Outpatient	3 DOA Other: 4 Nursing Ho	ome 5 🗆 Residence	6 Other (Specifi	)
27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 ☐ Yes 2 ☐ No	28d. Describe how inju	ury occurred	
27. Manner of Death 1 Natural 2   Accident investigation 3   Suicide   G   Could not be determined	28e. Place of injury - At home, farm, street building, etc. (Specify)	, factory, office	28f. Location (Street a City or Town, State	and Number or Rura e)	d Route Number,
29a. Certifier 1 Certifying Phys	sician: To the best of my knowledge, death or ner: On the basis of examination and/or invest and manner stated.	ccurred at the time, date and place stigation, in my opinion, death occu	, and due to the cause( rred at the time, date a	(s) and manner as s nd place, and due t	tated. o the cause(s)
29b. Signature and title of certifier		29c. License number	29d. Di	ate signed (Month.	Dav. Year)

RF-5-000

600 North Wolfe St, Baltimore, MD, 21287

DHMH 17 Rev 1/2001

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State Registrar

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31. Date filed (Month, Day, Year)

within 24 hours a

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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2. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene

			1 - State of Ma State Registrar			rtificate of				110	201.00		
Н	Physicia	an	1. Decedent's Name (First, Middle, Last)		Data			Date of Deal     Month	h Day	Year	3. Time of Death		
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	Examin	er	4a. Facility Name (If not institution, give street and number)  Household of Angels Assiste	d I f	vina		r Location of Deatl rna Park	1	4c. County		ndel Co.		
	Funeral		5. Social Security Number 6. Sex 7. Age		ast birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	1	9. Birtho	lace (State or Foreign		
	Director		213-01-6424 1□XM 2□ F 90	)	Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, Feb. 15	, 1919_	Mary	rland		
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	h the	irec	Maryland Baltimore  10e. Street and Number			10f. Zip Code	Dundar		0g. Citizen of W	hat Cour	try?		
	23a c	ral	6843 Boston Ave.				21222		United	Stat	es		
	er de	<b>Funeral Director</b>	11. Marital Status 12. Was Decedent I Armed Forces?		5. 13.	Was Decedent of I If Yes, specify Cub	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No- o Rican, etc.)		- Americ c, White, c	an Indian, etc.		
036	should be filled within 72 hours after death with the Maryland and Mental Hygiene. s marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examinar mast be redified at	by F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ N If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:	" WWII		1⊡Yes 2⊡xNo	Specify:		Specify:		White		
2-0	72 hou	Completed by	15. Decedent's Education (Specify only highest grade completed)	MMIT	16a, Dece	dent's Usual Occup	pation	ting	16b. Kind of Bu	siness/Inc	dustry		
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au	d be tental ked o	To Be	Joseph Peterson					Smiarows		-7			
ary	shoul and M s mar umat	-	19a. Informant's Name/Relationship (Type. Print)			ng Address (Street	and Number or Ru	ıral Route Numbei	, City or Town,				
Σ	and 2 ealth a n 27 is		Elaine Miller (Daughter)			Baltimo		lis Blvd	. Arno	ld, 1	MD 21012		
ore	ges 1 If iter or oth		20a. Method of Disposition 1 ★Burial 2 □ Cremation 3 □ Removal from State			sition (Name of matory or other pla			20c. Location -				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ite Medical Examinar must be refilled at once.		4 ☐ Donation 5 ☐ Other (Specify)	Sac		t. of Man					Maryland		
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			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin	the death	. Do not ent						Approximate Interval Between		
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part .	/Medical Examiner		nmediate Cause (Final sease or condition esulting in death)  a. CHRONIC OBSTRUCTIVE LUNG DISERSE  Due to (or as a consequence of):  CONGESTIVE CARDIOMYO PATRY  Due to (or as a consequence of):										
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ŏ	n certific anding p use as t	n/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome						23d. Date	of delive	ery		
P.O. Box	death ne atte	Physician/	in the past 12 months?  1 □ Yes 2 □ No  4 □ Pregnant a			☐ Ectopic pregnand ☐ Other <i>(sp</i> ec <i>ify)</i> _	У		Mor	nth	Day Year		
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Division of Vital	ding Physiclan: The I h. After this certificate ha funeral director, page	tion:	27. Manner of Death  1 Natural 5 Pending (Month, Day)  1 Accident investigation	Year)	28b. Time o Injury	Wor	ryat k? Yes 2 □No	28d. Describe ho	ow Injury occurre	ed			
/isi	Atten r deat sctor: by the	fica	3 Suicide 6 Could not be	ry - At hor	ṃe, farm, str		765 2 110	28f. Location (Si	reet and Numbe	er or Rura	al Route Number,		
á	rs afte al Dire	Certification:	4 ☐ Homicide determined building, etc	(Specify				City or Town	n, State)				
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of 2 Medical Examiner: On the basis of and manner sta	examinati	vledge, deat ion and/or in	h occurred at the ti vestigation, in my o	me, date and place opinion, death occu	e, and due to the durred at the time, d	ause(s) and ma ate and place, a	nner as s ind due to	stated. the cause(s)		
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			Melendels	MD		カコ	7157	(	DCTOBE	4 5	, 2009		
	5+1		30. Name and address of person who completed cause of de RAYNOLD DETESTIFE  31. Date filed (Month, Day, Year)  OCT 09 2009  32. Registra	ath (Item	23a) (Type, Lors)	Print) BALTIN	ORE DR	#110 /	BALTOMO	RE!	4021244		
	Stat Registra	_	31. Date filed (Month, Day, Year) 2009 3. Registra	r's Signat	e L	20	- 7				*		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OC TOBLY Year **Physician** Edmund Charles Piercy 2001 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Randallstown Baltimore Seasons Hospice 8. Date of Birth (Month, Day, Yo 12-17-1918 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2 □ F Months Days Hours Min Mary Land 90 Director 215-03-5388 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County id 2 should be filed within 72 hours after death with the Marylar Ith and Mental Hygiene.
27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Experience and be notified at 1 ☐ Yes 2 🕱 No Directo Woodlawn Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6825 Campfield Road 21207 U.S.A. Apt. 7H Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: 3 ₩ Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Secondary (0-12) College (1-4or 5+) 12 Letter Carrier Postal Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Piercy Nellie Hobbs 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is many injury or other traumonce. Mr. E. Christian Piercy - Son 1 E. University Parkway Unit 1411 Baltimore, MD 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Moreland Memorial Park 10-10-2009 Baltimore. Maryland 21. Sign vor of Funeral Service 22. Name and Address of Facility 5305 Harford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (o as a consequente of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or). The law requires that the death certificate be executed Exami attending physician and for use as the burial-transi Due to (or as a consequence of); Box 68760, Physician/Medical IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) ned by the a Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by t t be detach Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 No 3 Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performe 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Dother (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier l 📉 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

10

State Registrar x 16 bbis Burton

31. Date filed (Month, Day, Year)

32. Registrar

32. Registrar's Signature

of person; who completed cause of death (Item 23a) (Type, Print)

OLD COURT ROAD Randa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 1925 PM Theodore Paszula 2009 10 6 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** FRANKLIN Square Hospital Center Bactimore Rosedale If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) September 26, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours Min. New Jersey 1 ☑ M 2 ☐ F 141-40-9290 63 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exeminar must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Maryland N/A Baltimore ¥XYes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? USA 21214 3103 Echodale Avenue by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes 2XXNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 XX Married Specify: White 1 □Yes 2 X No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Book Keeper Prime Rib Restaurant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Walter Paszula Helen Rudek 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3103 Echodale Avenue Baltimore Maryland 21214 Ellen Paszula/Wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 10/12/09 Baltimore Maryland Hilltop Service Corp. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Leonard J. Ruck. Tinc |5305 Harford Roád Baltimore Maryland 21214 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a atherosclerotic cardiac vascular heart diease **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Dusito (or as a consequence of) the burial-tran Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) muer uns certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Smoker alcohol 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 4 hours after death. investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral L 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) E. Guon i (am, M) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 062019 -6-2009

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1 000 A

アウミエいしん Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

State Registrar OR ELIZabeth

31. Date filed (Month, Day, Year)

OCT 0 9 2009

9000 FRANKLIN Square DR Balto md 21237

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

H. Guondian

32. Registrar's Signature

Director

Completed by Funeral

Be

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Examine

Physician/Medical

Completed by

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Medical Certification: To

rilled in by the fi

within 24 hours after To the Funeral Direct

**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, It is It Safical Examiner must be refilled at anotes.

**Physician** 

/Medical

Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760

Baltimore, Maryland 21215-0036

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Days

Reg No	 1109.110.	-	~	4.7	not.	_
	Reg. No.	2			0	

3. Time of Death

2:28 PM M

Decedent's	Name	(First,	Middle,	Last)

6. Sex

1 € M 2 □ F

Kenneth S. Pierson

2. Date of Death 2, 2009 October

4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Fairhaven Retirement Center Sykesville

7. Age (In yrs. last birthday)

90

4c. County of Death Carroll If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Oct 21, 1918

155-01-9157 Usual Residence of Decedent

10c. City, Town or Location

 Birthplace (State or Foreign Country) New Jersey

10b. County MD Carroll

5. Social Security Number

Sykesville

10d. Inside City Limits 1 ☐ Yes 2√∑ No

10e. Street and Number

10f. Zip Code 7200 Third Avenue

10g. Citizen of What Country? 21784 USA

11. Marital Status

12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WW]

 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2X No

 Race - American Indian, Black, White, etc. Specify: White

1 ☐ Never Married 2 ☐ Married 3 Widowed 4 □ Divorced

Elementary/Secondary (0-12)

WWII 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+)

16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

16b. Kind of Business/Industry

17. Father's Name (First, Middle, Last)

salesman unk

furniture 18. Mother's Name (First, Middle, Maiden Surname)

unk

19a. Informant's Name/Relationship (Type. Print)

Fairhaven Retirement Center

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7200 Third Avenue Sykesville, MD 21784

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify)

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, State

21. Signature of Roperal Services icensee de Director

a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

State Anatomy Board 655 W. Baltimore Street Baltimore, MD Approximate Interval Between Onset and Death

Immediate buse (Final disease or condition resulting in death)

Sequentially list conditions, if any heading to turn outle cause. Enter Underlying Cause (Disease or injury that initiated events

Anorexia Due to (or as a consequence of): 1/2 herier o

monon

resulting in death) Last

Due to (or as a consequence of):

23d. Date of delivery

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

Month

9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

2 □ No

23e. Did tobacco use contribute to the cause of death?

Year

diseuse

24a. Was an

1' Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 No

Day

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No

determined

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day, Year)

and manner stated.

2 ER/Outpatient 3 DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d, Describe how injury occurred

27. Manner of Death 1 Natural

4 Homicide

5 Pending investigation 2 Accident 3 Suicide 6 □ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Yes 2 □ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one) 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Eldersburg

26. Place of Death (Check only one)

29b. Signature and title

29c. License number

29d. Date signed (Month. Dav. Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print) Illiam lan

1645 Liber Registrar's Signature

State Registrar

			1 - State of Ma	aryland		rtment of F tificate of I	lealth and M Death		ene j. No. 2 ()     9	12441
ı	Physicia /Medic		Decedent's Name (First, Middle, Last)  JEANNETTE		PUF	RETZ		2. Date of Death Month OCTOBER	Day 2009	3. Time of Death 7:20 A M
	Examin	er		HINGT		RO	CKVILLE		4c. County of Deatl	ERY
ı	Funeral Director		216-09-4371 1□ M 2X F	e (In yrs. las 92	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, ) 03/20/19	9. Birti Co.	hplace (State or Foreign untry) MD
	e Maryland 8a-f show	Director	Usual Residence of Decedent  10a. State	10c. City,	Town or Loc	CKVILLE				10d. Inside City Limits 1 ☐ Yes 2 🌠 No
	ath with the 23a or 2	ral Dire	10e. Street and Number 6121 MONTROSE ROAD			10f. Zip Code 20852			g. Citizen of What Co	
5-0036	urs after dea al", or items Exertainer m	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Nidowed 4 Divorced  12. Was Decedent E Armed Forces?  1 Tyes 2 Nith Year or Dates:		If	/as Decedent of H Yes, specify Cuba □Yes 2 <b>X</b> No	lispanic Origin? (Spo an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, White Specify: W	
21215-0	be filed within 72 hours after death with the Maryland that Hygiene. Id other than "natural", or items 23a or 28a-f show event, the Mysical Exemple mast by notified at	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5-12)		(Give k life. D	ent's Usual Occup cind of work done o O NOT use retired [MS EXAM]	during most of worki i)	ng l	SDCIAL S	
Maryland 2	d d d	o Be Co	17. Father's Name (First, Middle, Last)	LEV			18. Mother's Name	(First, Middle, Ma		
	d2s Ithar 17is trau		19a. Informant's Name/Relationship (Type. Print)  ELLIOTT PURETZ / SON		`	,	and Number or Rura		City or Town, State, Z	tip Code) 459
altimore,	Pages 1 an nent of Hea ant: If item 2 ary or other		20a. Method of Disposition 1 (X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	Ang	ce of Dispos Patery, chern T CHA	ition (Name of atory or other plac UNAH TM	10/08		Dc. Location - City or BALTIM	Town, State  ORE, MD
Balt	permit. Page Department ( Important: If any injury or once.		21. Signature of Funeral Service Licensee	2050-513	22.	Name and Addres	001		ON & BROS. KESVILLE,	
	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each lin Immediate Cause (Final disease or condition resulting in death)  Due to or as a	NEI	имо	r the mode of dyin	ng, such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
160, 4	icate be executed was physician and and the burial-transit	sal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a Due to (or a) Due to (or		·					
O. Box 68	death certil e attending d for use as	Physician/Medical	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown	2 Fetal d	eath 3 🗌	Ectopic pregnanc Other (specify)	у		23d. Date of del Month	ivery Day Year
rds, P.	law requires that the dras been signed by the 2 should be detached	þ	Part II. Other significant conditions contributing to death but	ut not resulti	ng in the un	derlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
al Records,	The la	Completed						24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of 2 □ No
or Vital	Physician: The this certificate ral director, pag	To Be		ent 2□EF			er: 4 Nursing Ho		ce 6 ☐ Other (Spe	cify)
DIVISION (	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	27. Manper of Death  1 Natural 5 Pending (Month, Day  2 Daccident Investigation  3 Suicide 6 Could not be	y, Year)	8b. Time of Injury		Yes 2 □No	28d. Describe how		- De la Nombre
2	pital or A		28e. Place of Injubiliding, etc				(i	City or Town,		
6	To the Hospital or within 24 hours afte fo the Funeral Dir. completely filled in	Medical	(Check only one)  2 Medical Examiner: On the basis of and manner sta	f examinatio	n and/or inv	estigation, in my o	ppinion, death occur	red at the time, dat	te and place, and due	to the cause(s)
	5 7 ½ T		Demacella	un	00-1/7	D 018	7084			
			30. Name and address of person who completed cause of do DINGSH D ATEL M 31. Date filed (Month, Day, Year) 32. Resisted	.9. 6	2121	MONTA	205E RI	) Rec	Kulle M	206,2009
	Sta Registra		OCT 0 9 2009	and a	1 1	ended)			,	

DHMH 17 Rev 1/2001

JEANNE

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death EUGENE WILLIAM PLUNKETT 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin. timore Under 1 Year | If Under 24 Hrs. 8. Date of Birth November 7, 1920 9. Birthplace (State or Foreign 5. Social Security Number Days **X**XM 2□ F Mary Tand 88 217-09-6673 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2√12 No Baltimore Chase Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 USA 12829 Eastern Avenue 12. Was Decedent Ever in U.S. Argued Forces? Argues 2 □ NoWWII If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Never Married 2 Married 1 □Yes 2**XX**No White Specify: Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLothing Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edward Plunkett Elizabeth Brian 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) PR 12829 Eastern Avenue Chase MD 21220 Calvert C Gray 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial XXX Cremation 3 ☐ Removal from State GreenMount Crematory Oct 9, 2009 4 Donation 5 □ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Mitchell-Wielefeld Funeral Home Inc gnature of Funeral Sa vice Licensee 6500 York Road Baltimore, Maryland 21212 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) piratory Due to (or as a consequence f): piration DEUMONIA Due to (or as a consequence of): Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23d, Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 9 Unknown

**Physician** /Medical **Examiner** 

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien Important: If item 27 Is marked other the any injury or other traumatic event, Italy once.

**Physician** 

/Medical

Examiner

10a. State

Director

by Funeral

Be Completed

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**Funeral** 

Director

d other than "natural", or Items 23a or 28a-f show event, the Modical Examinar must be notified at

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-tran attending physiciar as the l for use page 2 should

after death

Hospital or Attending Physician: The law requires that the death certificate be executed

the

Box 68760

P.0.

Records,

**Division of Vital** 

Physician/Medical ģ Be Completed Medical Certification: To

Examiner completely filled in by the funeral director, 24 hours a Funeral I within 2

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 23b. Was decedent pregnant in the past 12 months? □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1 □Yes 2 **N**o 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manger of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D6904

2009

Square Drive, Baltimore, Maryland 21237

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month Day, Year) 0CT 0 9 2009

Amend Item 9,11 per inf.,g897,11/05/09dhb/dk
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #9,11,15,16a&b,18&19a&b, Per, ANA, BD, G985,9/16/09 JH

1- For Amend Items 25,27,28a-1 per me,g896,10/08/09dhb
Certificate of Death
Registrar

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** P M Clarence H. Robbs 2:16 09 05 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Greater Baltimore Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 22, 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) 1942 Haryland SC unk Days Hours Months 1 ₹ M 2 □ F 67 220-36-2042 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show death with the Marylan permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination to other traumatic event, If a Medical Examination and 1 ☐ Yes 2√☐ No Director Baltimore Towson MD10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 305 E. Joppa Road #2202 21204 USA Funeral 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lif Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: black ò 3 Widowed Wivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Cab Driver Transportation unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be 2 Anna Jolly 19a Joann's Califfamatic/Courseln 19b9Ma(Te did rev 600dt a Chrobler Rup Tkees vret Lev or MD1, 2ale208 ode) Greater Baltimore Med Ctr 6701 N. Charles Street Towson, MD 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 

Other (Specify) in state 21. Signature of Euneral Service Licenses Ronald Stade, Director 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. hrt1. Enter the isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** WEN /Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) requires that the death certificate be executed burial-tran and Box 68760, the attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 2 No □Yes P.O. detached 9 Unknown 9 Unknown á signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performe /es 2 certificate Vital 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 ð this 28a. Date of Injury
Fo(!11et/n Day, Year)
08/31/2009 Unknown 27. Manner of Death 28d. Describe how injury occurred After t 28c. Injury at Work? Certification: Division Hospital or Attending 5 ☐ Pending investigation **Nat**ural 2 Accident death. 1 ☐ Yes 2X No Subject fell. within 24 hours after death

To the Funeral Director:
completely filled in by the in by the 3 ☐ Suicide 6 ☐ Could not be 28t. Location (Street and Number of Rural Route Number City or Town, State) 305 E. Joppa Rd., 2202, Towson, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Home 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) Medic and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Monthy Day, Year) Name and address of person who leted cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day,

32. Registrar's

Baltimore, Maryland 21215-0036

DWAR

P.O. Box 68760,

Division of Vital Records,

KM

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Edward Frank Rostek 5:00 AM 2009 04 10 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death S. Date of Birth (Month, Day, Year)
Oct. 4, 1924

9. Birthplace (State or Foreign Country)
Poland Social Security Number Date of Birth (Month, Day, 1 📉 M 2 🗆 F Months Days Hours 85 219-18-6508 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, fire Medical Examinar instal by a collider an once. Director 1 ☐ Yes 2 No MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21128 USA 9608 Amberleigh Lane Unit E Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Xes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White etc 1 ☐ Never Married 2 X Married ģ If Yes, Give Year or Dates: 1 ☐ Yes 2 XNo Specify: white Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Commerical/Residental Elementary/Secondary (0-12) College (1-4or 5+) Cabinet Maker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Rostek Mary Jamrosz 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21128 Mary Rostek-spouse 9608 Amberleigh Lane-Unit E, Perry Hall, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place Parkwood Cemetery Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Oct.8,2009 Parkville, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS FUNERAL CHAPEL AND CREMATION SERVICES Londral h ME Ford 8800 Harford Road-Parkville, Maryland 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** INTRACEREBRAL resulting in death) /Medical Due to (or as a consequence of): Examiner COAGULOPATH Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burish-transit attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 ☐ Other (specify) 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAILURE 1 ☐ Yes 2 ☐ HNO 3 ☐ Probably 4 ☐ Unknown BRILLATION ATRIAL 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? CONGESTIVE 1 ☐ Yes 2 ☐ No 1 □Yes 2 □-Mo 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a Certifier 1 🖳 ceffifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 10/05/09 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GOOD SAMARITAN HOSPITAL BELRASE 560L LOCH RAVEN BLVD, BALTIMORE, MD 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

**ORIGINAL** 

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

#### 09-07795 Tho

### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Physicia	an/	Registrar  1. Decedent's Name (First, Middle,L.						2. Date of Deat	h	Year	3. Time of Death
edical Exami	ner	Thomas Sariego  4a. Facility Name (if not institution, or	nive street and number)		Ah City	Town or Loc	cation of Death	Month October 7,	2009	nty of Death	1530 hrs
		University Hospital	ive street and number)			imore	odion or Bodin		10. 000.	ity or Boutin	
Funeral		· ·	Sex 7. Age (In	yrs. last birth		der 1 Year ths Days	If Under 24Hrs Hours Min.	_	h(MM/DD/Y	Foreign	hplace (State or n
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any		Usual Residence of Decedent  10a. State  10b. County	10c	. City, Town o	r Location				-		10d. Inside City Limits
*	ō	Maryland		Baltim	ore						1 X Yes 2 No
Maryl r 28a-i ed at o	Director	10e. Street and Number				ip Code		10		f What Coun	ntry?
vith the \$ 23a o	eral D	1447 Light Street	12. Was Decedent Eve	r in Ú.S.		21230 dent of Hispar	nic Origin? ( Sc	pecify Yes or No-	U.S.		can Indian, Black,
death v r items	Funer	1 Never Married 2 Married	A				lexican, Puerto			Vhite, etc.	,
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036 ithin 7 ene. er than	mple	12		So	ldier				U.S.		
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212 ould be I Ments s mark ic even	To Be	19a. Informant's Name/Relationship	(Type, Print )	19b.	Mailing Addre		Evelyn I	Rural Route Num	ber, City or	Town, State	, Zip Code)
MD 2 shalth and 27 is aumat		Heather Osborne (	·					Baltimo		iarylar	nd 21220
Baltimore, MD 21215-0036  permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medikal Examiner must be notified at once.		20a. Method of Disposition  1 X Burial 2 Cremation	3 Removal from State	cremato	Disposition (N	:e)	.				
Itim tit. Pag urtment ortant:		4 Donation 5 Other Speci 21. Signature of Funeral Service Life	ny.	магута				14/2009			Forest, Md.
Dept.					1407	old Ea	zdzínsk istern	i Funera Avenue,	l Hom Essex	e, P.7 , Mary	A yland 21221
Physician /Medical		23a. Part I Enter the disease, or confair re. List only one cause on	each line.		enter the mod	e of dying, su	ch as cardiac c	or respiratory arre	est, shock, o	r heart	Approximate Interval Between Onset and
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	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	Due to (or as a conseque c.	ence of):							
recuted and transit	Exar	events resulting in death) Last	Due to (or as a conseque d.	ence of):							89
ज ज ल	Physician/Medical	UNPENDED	AMENDED				-				
760, icate be sphysici the buri	/Mec	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome o	of pregnancy			·			te of delivery	
Box 6876 death certificat he attending ph	iciar	past 12 months?	1 Live birth 4 Pregnant at time	e of death 5	Fetal dea Other (S)		Ectopic pregna	ancy	Mon	un L	Day Year
). Bo the deal by the al	hys	Yes 2 No 9 Unkno	9 Unknown	t not reculting	in the underly	na cause aive	en in Part I	23e Did to	phacco use o	contribute to	the cause of death?
P.O.	by	ratti. Other significant condition	s contributing to death bu	it not resulting	iir tile tilideriyi	ng cause give	en in rait i.				bably 4 Unknown
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tal Recian: The	Be C	25. Was case referred to medical examiner?					Death (Check	only one)			
of Vital Records, P. g Physician: The law requires the Arthur this certificate has been signe neral director, page 2 should be de	ဥ	1 ✓ Yes 2 No  27. Manner of Death	Hospital: 1 Inpatient  28a. Date of Injury	2 ✔ ER/Ou	tpatient 3	DOA Ot		ng Home 5	Residence		r:
on of ending Pl ath or: After he funera	Certification:	1 V Natural 5 Pending	(Month, Day,Year)	200.1	mic or injury		s 2 No	20d. Describe	now injury or	Journey	
Division tal or Attendiins after death al Director:	ifica	2 Accident Investig 3 Suicide 6 Could n	28e Place of Injury	- At home, far	rm, street, facto	ory, office buil	ding, etc.	28f. Location (		umber or Ru	ural Route Number, City
Division ospital or Atten hours after death meral Director:		4 Homicide determine 29a, Certifier 1 Certifying Physics	(								
To the Hospita within 24 hours To the Funeral completely fille	Medical		sician: To the best of my kn ner:On the basis of examina								
To For	Me	29b. Signature and title of certifier	and manner stated.			29c. License r	number		29d. Date	signed (Mo	nth, Day, Year)
4-1		(	M. Co			O.C.M.	.E.		Octobe	r 8, 2009	
ax		30. Name and address of person of Jack Titus MD. Deput	no completed cause of death by Chief Medical Exar	,	1 Penn Str	eet, Baltin	nore, MD 2	1201			
	tate	31. Date filed (Month 4e) (Yes) 2	<i>D</i>	Signative	.0 ==	2					
Regis	trar	AAIAA	and Kenna	10.	PAR						COME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Georgia Belle Sheets OB 6:15AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Franklin Woods Nursing Center Rosedale Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months 1 ☐ M 2 🔀 F 218 54 0639 64 Director North Carolina April22,1945 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show notified at Baltimore 1 ☐ Yes 2 No Maryland Middle River Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be a 3 Chandelle Rd 21220 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 🔀 No Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 12 Department of Health and Mental Hy, Important: If them 27 is marked othe any injury or other transment. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dave Hill Jr. Hassie Tyler 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bobby W. Sheets (Son) 3 Chandelle Rd. Baltimore, Maryland 21220 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 □Cremation 3 □Removal from State Holly Hill Mem. Gardens 10/12/2009 Baltimore, Maryland 4 Donation 5 Dother (Specify) 21. Signature/of Funeral Service License Bruzdziński Funeral Home P.A. 1407 Old Eastern Avenue Essex, Maryland 21221 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner nters Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last to (or as a consequence of) Examiner attending physician and for use as the burial-transit -mona Due to (or as a consequence of P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No the 9 Unknown 9 I Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed? Yes 2 No certificate 1☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 🔼 No P 1 ☐ Inpatient 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation Injury within 24 hours after occ...

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

Avenue, Buetimore

29d. Date signed (Month, Day, Year) 101081

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year OCTOBER Francis Edward 2009 Streett /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Center Baltimore 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Funeral 6 Sex Days 1 XM 2 F Michigan Director 213-28-8560 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Exactions is used be notified at 1 Tyes 2 THO Director Balto. Kingsville Md. 10e. Street and Number 10g, Citizen of What Country? ō 21087 USA "natural", or items 23a 12225 Philadelphia Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, its Medical Ext. in an any injury or other traumatic event, its Medical Ext. in an any injury or other traumatic event, its Medical Ext. in an any injury or other traumatic event, its Medical Ext. in an any injury or other traumatic event, its Medical Ext. in an any injury or other traumatic event. Black, White, etc. 1 Never Married 2 Married 1 □Yes 2 🛣No White λq Specify Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C&P Telephone Co. 12th Switchman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth W. Frank Joseph I Streett ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 Miller Rd. Kingsville, Md. 21087 19a. Informant's Name/Relationship (Type. Print) Tracy Miller DTR. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview 10-12-2009 Balto. Md. 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee ing U 9705 Belair Rd. Nottingham, Md. 21236 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIAC FAILURE **Physician** disease or condition resulting in death) HOURS /Medical Due to (or as a consequence of): **Examiner** ATHEROSCLEROTIC CORONARY ARTERY DISEASE YEARS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Proneral Director: After this certificate has been signed by the attending physician and letely filled in by the funeral director, page 2 should be detached for use as the humal transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC RENAL FAILURE 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an autopsy 2 **N**o 1 Tyes 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24

To the F

complete 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M D38655 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) STEWART FINNEY. M. D. 7621 OSLER DRIVE TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) OCT 0 9 2009 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Physician Day Year Bernard 8:51 A M /Medical 10 06 2009 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Samaritan (500d Hospital Baltimore Baltimor If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. 5 (Month, Say, 5. Social Security Number 7. Age (In vrs. last birthday)

7. Yrs. **Funeral** 9. Birthplace (State or Foreign 212-28-7725 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits Baltimore MD Completed by Funeral Director 1 Ses 2 □ No 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with til Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Exaction traust Lerne once. 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 □ No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🌠 o Specify. 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary (Secondary (0-12) College (1-4or 5+) Father's Name (First, Middle, Last) Be ဥ 19b. Mailing Address (Street and Number or Raral Route Number, City or Town, State, Zip Code) Balto, MD 21213 Woodstoc 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other to Owings Mills, MD Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 21. Sign arr of uneral Service Licensee 23a. Part 1. Enter the lisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ver /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760, Due to (or as a consequence of): attending physician Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day signed by the a d be detached f ☐Yes 2☐No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Â₽No P 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Medical Certification: 28d. Describe how injury occurred 5 Pending investigation Natural 2 Accident 1 ☐ Yes 2 🗆 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0069314 10,06,2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Woods Rd, Parkville, MD 21234 Praj a parti

State Registrar 31. Date filed (Month, Day, Year)

OCT 0 9 2009

DHMH 17 Rev 1/2001

8813 Waltham

32. Registrar's Signature

David Stanley Se				e of Marylar	nd / Depa	artment o	of Hea	lth an				gible.	A IN	0 00:1
Physicia	ın/	Registrar  1. Decedent's Name  DAVII				rtificate o		uri		2.	Date of Deat	eg. No. th Day Year		Time of Death
Medical Exami	ner	4a. Facility Name (if		STANLEY ive street and num		SELING		Town, or	Location of		Month October 5	, 2009 4c. County o		1618 hrs
		8111 Philade						edale	Len	. 0.411 1	0 D-1 ( D'-	Baltimore		
Funeral Director		5. Social Security No. 218-36-	2526	Sex 7	, Age (In yrs. I	69 Y	Monti	hs Day		Min.	1 – 7 – 1	` '	9. Birtingi Count	lace (State or Foreign ry) MD
any		Usual Residence of 10a. State			10c. City	, Town or Loca	ation						10	Od. Inside City Limits
<b>*</b>	ō	MD	BAI	TIMORE		,			ROSE	DALE				Yes 2 No
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show s injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Num 8113 PI		T AVENU	JE		10f. Zij	p Code	2123	7	1	0g. Citizen of Wh		S.A.
th with the ems 23a	era	11. Marital Status  1 X Never Marrie	d 2 Marrie	12. Was Dece				lent of His		in? ( Spec	sify Yes or No	14. Race White	- Americar	n Indian, Black,
nfier dea il", or it	y Fun	3 Widowed		1 Yes	2 X No		Yes 2				,	Specify:		ITE
? hours a	ted by	15. Decedent's Edu		only highest grade		16a. Decede during			tion (Give k			16b. Kind of Bus	iness/Indu	ustry
5-0036 led within 77 Hygiene. other than	Completed	8	, ,				BUIL					SELF 1	EMPL	OYED
215-( be filed v ntal Hygi ked oth	Be Co	17. Father's Name (F BERNARD			ELING	, SR.		İ		s Name (F <b>VEVI</b>		Maiden Surname)	(KAH	LER)
MD 21 Id 2 should 1 If and Mer aumatic ev		19a. Informant's Nar EUGENE			!R				et and Numi			nber, City or Town		
re, M s i and 2 f Health ff item 2 er traun	1	20a. Method of Dispo	osition		20b.	Place of Dispo	osition (Na	me of ce	metery.		Date	ROSEDAI		
Baltimore, permit. Pages I an Department of Her Important: If ite			Other Specia	fy:	OA	crematory or o					9-09			E, MD
Ba perm Depa Impq injur		-	20	- ( 5	10	1	211	CHE	SACO	AVE	ROS	EDALE,	MD	ERAL HOME 21237
Physician /Medical			one cause on			n. Do not enter	the mode	of dying,	, such as ca	rdiac or re	espiratory arr	est, shock, or hea	rt	Approximate Interval Between Onset and Death
( `xaminer		Immediate Cause (F or condition resulting	g in death)	Due to (or as a c		of):								
	iner	Sequentially list con if any, leading to immanded cause. Enter Under	nediate	Due to (or as a c	onsequence o	of):								
red / /	Examiner	(Disease or hijury the events resulting in d	eath) Last	Due to (or as a c	onsequence o	of):								
), be executed ician and urial - transit	dical	UNPENDED		AMENDED										
68760 certificate b nding physise as the bu	ŝ	IF FEMALE: 23b. Was decedent p		23c. If yes, ou			etal death	3	Ectopic	pregnanc	sy	23d. Date of Month	delivery Day	Year
0 ta ta 5	<b>1</b>	past 12 months?			nt at time of de	eath 5 (	Other (Spe	ecify)						
P.O. Es that the case that the case detached	by Phy	Part II. Other signifi	cant conditions	contributing to o	death but not r	resulting in the	underlyin	g cause	given in Par	rt I.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	obacco use contri		
rds, Frequires											24a. Was	an 24b. V	/ere autop	oly 4 Unknown
Recol The law cate has	Completed						•				autor perfo 1 ✓ Yes	rmed? d	rior to con eath? ✓ Yes	npletion of cause of
/ital Fician:	Be	25. Was case referre examiner?	, III	Hospital:	patient 2	ER/Outpatier	nt 3	26.Place	of Death (	Check on		Residence 6	Other: S	cene
Division of Vital Records, tal or Attending Physician: The law requins after death al Director: After this certificate has been sited in by the funeral director, page 2 should be	입내	1 Yes 2 27. Manner of Death 1 Natural		28a. Date of Oct 5, 200	f Injury	28b. Time of 1611 hrs		28c. Inju	ry at Work?	28	8d. Describe	how injury occurre by machine		
Division pital or Attencours after death teral Director: filled in by the	ertification:	2 Accident 3 Suicide	5 Pending Investiga 6 Could no	tion 28e Place		ome, farm, str	eet, factor		Yes 2	No			er or Rural	Route Number, City
Division  To the Hospital or Attentwithin 24 hours after death To the Funeral Director: completely filled in by the	0	4 Homicide	determin	ed (Specify)								lphiaRoad , Ros		MD
To the Hospita within 24 hours To the Funeral To the Completely fille	io I	(Check only		cian: To the best on er:On the basis of and manner sta	examination a									cause(s)
	ž	29b. Signature and ti	tle of certifier				29	O.C.	e number			29d. Date signe October 6,		, Day, Year)
	+	30. Name and addre		•	,									
St.	ate	Ana Rubio M	D. Assista	ant Medical Ex	kaminer istrar's Signati	111 Penn		Baltimo	ore, MD 2	21201				
Regist	ar	CCT	0 9 2009	Dener	N 1.	Bark	Les !							

			1 - State of Maryland / Department of Health  Certificate of Death		ygiene Reg. No.	2009	32449
	Physici		1. Decedent's Name (First, Middle, Last) Nellie Hart Spahn	2. Date of Do Month October		2009	3. Time of Death 06:58 A M
w	/Medid Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location  Shangri-La Assisted Living  Ellicott City	n of Death	4c. County of Death Howard		
	Funeral Director		5. Social Security Number 214-22-2760 6. Sex 1 D M 21 P 97 Yrs. Social Security Number 1 D M 21 P 97 Yrs. Social Security Number 1 P P P P P P P P P P P P P P P P P P	er 24 Hrs. 8. Date of Bi		9. Birtho	place (State or Foreign htry) 81a
	Maryland a-f show	ctor	Usual Residence of Decedent  10a. State			1	0d. Inside City Limits 1 ☐ Yes 2 ☑ No
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 210f. Zip Code 21042		10g. Citiz	en of What Coun	itry?
980	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, it is Marken Evanther must be nothing at	þ	11. Marital Status  1 Never Married 2 Married  12. Was Decedent Ever in U.S. Armed Forces?  14. Yes 2 No If Yes, specify Cuban, Mexica Status  14. Was Decedent of Hispanic O If Yes, specify Cuban, Mexica Status III Never Married 2 No If Yes, Sive 45 – 46 Year or Dates:		1	4. Race - Americ Black, White, e Specify: Whit	etc.
21215-0036	within 72 ho liene. r <b>than "natu</b> i fre Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  Registered Nurse	ost of working		d of Business/Inc	fustry
and	d be filed ental Hyg ked other c event,	To Be C	17. Father's Name (First, Middle, Last)  18. Moth	her's Name (First, Middle	e, Maiden S		-
Mar	1 and 2 should Health and Mer tem 27 is marke other traumatic	ř	19a. Informant's Name/Relationship (Type. Print) Eleanor Sullivan Daughter 3479 Walker Drive	ber or Rural Route Numb	ber, City or	Town, State, Zip 0 21042	Code)
Baltimore,	permit. Pages 1 a Department of He Important; If iten any injury or oth		The bolitation of bottomy)		Balti	cation - City or To Lmore, M	aryland
Ra	permit Depar Impor any in once.		21. Signature of Funeral Service Licens  22. Name and Address of Facility Funeral Home of 1630 Edmondson	itySterling A Catonsvill Ave. Catons	shtor e, Ir ville	schwab c. MD 212	Witzke 28
	Physician /Medical Examiner		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	is cardiac or respiratory a	arrest,	1	Approximate Interval Between Onset and Death
68760,	tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate cause Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of):  c			- 2	
. O. BOX 52	# 50 KB	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes   2 No   9   Unknown   23c. If yes, outcome of pregnancy   1   Live birth   2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown   9		23	3d. Date of delive Month	ery Day Year
ords, r	equires that en signed t	<u>م</u>	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part		tobacco us		ne cause of death?
vital Records	an: The law re tificate has be or, page 2 sho	e Completed	25. Was case referred to medical	1 □ Yes	psy ormed? 2 No		osy findings available inpletion of cause of
VISION OF V	ng Physi fter this c	Certification: To Be	Hospital: 1   Inpatient   2   ER/Outpatient   3   DOA   Other: 4   Ni   Ni   Ni   Ni   Ni   Ni   Ni	ee of Death (Check only of Nursing Home 5 Resi	idence 6	/	, Assisted
ב ב	ortal or At urs after d aral Direct illed in by		4 Homicide determined determined building, etc. (Specify)	City or To	wn, State)	Number or Rural	
;	lo the hospital of Attendi within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical	29a. Certifier (Check only one)  1	eath occurred at the time,	date and p	place, and due to	the cause(s)
	Z × 2 0		29c. License number  Lika Dhawar, M. 29c. License number  D 006  30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  NTA DHAWAN, M. 9055 Chevrolet Druce, S  31. Date filed (Month, Day, Year)  QCT 0 9 2009  A Segistrar's Signature  A Sparker	2534	10 0	signed (Month, I	) A Year)
\			30 Name and address of person who completed cause of death (Item 23a) (Type, Print)  NTA DHAWAN, MD 9055 Chevrolet Duice, S  31 Date filed (Month Day Year)	inte 103, E	MID	TT CIT -210	42
	Stat Registra	e r	act 0 9 2009 Leve S. Janes				

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OCT. Day 2009 Year 5:380 Theresa A. Snowden 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Franklin Square Hospital Rosedale Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 23, 1960 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) Months Days Hours 1 M 2 M 215-90-5436 49 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Middle River 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 415 Bowleys Quarters Road 21220 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ∐Yes 2 ⊠ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify. White Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) n/a Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Wesley W. Snowden Barbara M. Brokus 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Snowden /brother 1010 Meadow Glen Road Baltimore MD 21220 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Holly Hill Cemetery 10/8/09 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 Donation 5 Dother (Specify). 21. Signature of Funeral Service Uten e 22. Name and Address of Facility 300 Mace Ave. Balto. MD Connelly Funeral Home of Essex 21221 23a. Part 1 Enter the disease, or complications that a used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Immediate Cause (Final pira disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy ☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 No 2 🗌 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ TR/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Examiner death certificate be executed burial-transi physician sthe burial Box 68760, attending p for use as t Records, P.O. the signed by t I be detach certificate has been a rector, page 2 should aw page Hospital or Attending Physician: The Division of Vital this

After thi funeral of within 24 hours after death.

To the Funeral Director: A completely filled in by the fu death.

**Physician** 

/Medical

Examiner

MD

Funeral Director

Completed by

Be

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Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Exeminer must be redified at once.

**Physician** 

/Medical

Baltimore, Maryland 21215-0036

þ Completed Be

Physician/Medical Medical Certification: To

Exami

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

3 ☐ Suicide

4 ☐ Homicide

(Check only one)

MD

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

Avenue, Buetimore MD 21221

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1124 Mace nukwuma

6 ☐ Could not be

determined

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month **Physician** <u>12:3</u>0P <sup>™</sup> October 2009 4, David A. Sours /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Crownsville Anne Arundel 310 Severn Road If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours **¼** M 2 □ F Months Days Sept 7, Maryland Director 218-46-6523 61 Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at 1 TXYes 2 □ No Directo Maryland | Anne Arundel Crownsville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number with 21032 United States 310 Severn Road Funeral Pages 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ▼Yes 2 No If Yes, Give 11. Marital Status 1 ☐ Never Married ¾☐ Married Baltimore, Maryland 21215-0036 "natural", or 1 □Yes 2X□No Specify: 2 Specify 3 Widowed 4 Divorced Year or Dates: 1966-68 White Completed permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natur any injury or other traumatic event, the Medical once. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) **BGE** Elementary/Secondary (0-12) College (1-4or 5+) Overhead Distribution 9th Foreman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ၉ Μ. Sours, Jr. Edna Jean Reckline 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce C. Sours/wife 310 Severn Road Crownsville, Maryland 21032 Date 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery 10/8/2009 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home & Crematory, Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 Manita Thomas 23a. Part 1. There the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** years disease or condition resulting in death) Lung Cancer /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or nijury that initiated events resulting in death) Last Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 1 ☐Yes 2 ☐No ed by the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown ficate has been sign, r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 ☑No this certific al director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မှ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No n 24 hours after death.

e Funeral Director: A steely filled in by the fu 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check on within 2 one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 5272 10 ed cause of death (Item 23a) (Type, Print) 30. Name and address of person who comp 300 1/4 9 32. Registrar's Signature 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 28a per me, 8896,10/14/09dhb

Amend Items 2884codd Maryland The agreement 10/1946 Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Smallwood **Physician** 1809 1 bert 2009 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 05 pi+21 ernan Baltimore If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) **Funeral** Year) Days Hours 1**2** M 2□ F Months 213-78-8969 50 Director Maryland Usuat Residence of Decedent Manyland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location or 28e-f shov Examine coust by notified at 1√2 Yes 2 No MD Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 356 S. Pulaski Street 21223 USA Itams 23a by Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 ☐ Married ŏ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: black 3 ☐ Widowed 4 ☐ Divorced "netural", Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) 9 sanitation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be filt Department of Health and Mental Hy Importent: If Item 27 Is marked oth any injury or other treumatic event 2008. unk Be Robert Smallwood ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2200 Kernan Drive Baltimore, MD Kernan Hospital 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 ♥OTher (Specify) in state 21. Signature of Funer 15 rvice Licensee Conald S Wa 22. Name and Address of Facility Warde State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Myocardial months Interction Physician 2 /Medical Due to or as a consequence of) Examiner VICA CERTIFICATI TOPONED BY MEDICAL EXAMINER Sequentially list conditions. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician Box 68760 Physician/Medical IF FEMALE esn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy jo Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No detached the o 9 Unknown 9 Unknown ģ ئ Signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 3 Probably 2 🗆 No 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed certificate 1 Yes 2 No of Vital o the Hospitel or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury 28c. Injury at Work? Subject Certification: 28b. Time of 28d. Describe how injury occurred After t Division 1 Natural 5 Pending fell Unknown M 1 ☐ Yes 2X No down death. 5+2115 investigation 2 Accident Director: 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

Home 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 356 S. Pulaski St. In by hours after 4 Homicide within 24 hours af To the Funerel D Baltimore, MD 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD D0044635 09, 22, 2009 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kernen Drive Boltimore, Md. 2511500 ٥ 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			T- State of Maryland Registrar		artment of F rtificate of I			iene eg. No.	0.03	201.5
			Decedent's Name (First, Middle, Last)		- Intouto or I		2. Date of Deat		Year	3. Time of Death
	Physici /Medio		Rosalie E. Sterling				Sept.		:009	06:18 A M
	Examir	ner	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Deat	h	4c. County		
anger 1	Euperal		Anne Arundel Medical Center  5. Social Security Number 6. Sex 7. Age (In yrs. las	st birthdav)	A If Under 1 Year				e Aru	ace (State or Foreign
	Funeral Director		212-40-3012 1 M 2X F 68	Yrs.	Months Days	Hours Min.		Year) 1941	Cour	yland
	, ind		Usual Residence of Decedent	Town or Lo	ention					0d. Inside City Limits
	f shore	or		TOWIT OF LO	_					1 ☐ Yes 2¶ No
	r 28a-	Director	MD Anne Arundel  10e. Street and Number		10f. Zip Code	ern	1	0g. Citizen of \	What Coun	try?
	th with		7916 Tower Ct.		21	L144		Unit	ed St	tates
	tems	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. \	Was Decedent of H f Yes, specify Cuba	ispanic Origin? (S in, Mexican, Puerl	pecify Yes or No- to Rican, etc.)		e - Americ ck, White, e	
36	72 hours after death with the Maryland 'natural'', or items 23a or 28a-f show dieal Expreirer must be rofified at	by F	1 Mover Married 2 Married 1 Mover Married 2 Mover Married 2 Mover Married 1 Mover M	1	1 □Yes 2【X No	Specify:		Specify	: Wh	ite
5-0036	d within 72 hours a giene. er than "natural", o , Its Medics Exer		15. Decedent's Education	16a. Deced	ient's Usual Occup	ation	1.1	16b. Kind of B		
Ž	ithin 7 ne. ''r Mad	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)		kind of work done of OO NOT use retired		rking			
2	e filed within 7 al Hygiene. other than "r vent, the west		12 17. Father's Name (First, Middle, Last)	Adı	ult Caret		ne (First, Middle, M			sidence
Maryland	2 should be filed and Mental Hygi Is marked other raumatic event, It	Be G	Milton R. Sterling				ine A. Mc			
a Z	shoul and Ma s marl umatl	၉	19a. Informant's Name/Relationship (Type. Print)	19b. Mailin	ig Address (Street					Code)
Ž	and 2 salth s n 27 ls		David M. Sterling / Brother	574	Palisades	Blvd. C	rownsvil	le, Mar	ylan	d 21032
ore,	ges 1 t of Ho If iten or oth		20a. Method of Disposition 20b. Place cert 1 X Burial 2 □ Cremation 3 □ Removal from State 0117	ce of Disponetery, cren	sition (Name of natory or other place of the F emetery	e)	Date	20c. Location -	City or To	wn, State
Baitimor	it. Pag rtmen rtant: njury		4 □ Donation 5 □ Other (Specify) Chur	rch Ce	emetery	10-0	6-2009	Millers	ville	e, Maryland
g	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic e once.		21. Signal vire of Funeral Service Licen See		Name and Address Donaldso 1411 Ann	n Funera	1 Home & load Oden	Cremat ton, Ma	ory, irylai	P.A. nd 21113
			23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.				or respiratory arre	est,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	e	Myocar	rdial	Myara	Hou		Onset and Dead
-	Examiner		Due to (or as a consequen	nce of):						
	D #	Je.	Sequentially list conditions, if any, leading to in modate cause. Enter Indepture.	ios of):						
	ecuter and transi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence)							
8/60,	be ex iician burial		Due to (or as a consequent	nce of):						
200	ificate g phys	edical	d							
ŏ	th cert ending	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal decedent		Ectopic pregnance			23d. Da	te of delive	ery
	e dea the att ned for	sicis	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of dea		Other (specify)	у		Mo	onth	Day Year
Ţ.	hat the sd by detach		9 ☐ Unknown  Part II. Other significant conditions contributing to death but not resulting	no in the un	ndertving cause give	en in Part I	23e. Did tob	pacco use conf	tribute to th	ne cause of death?
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ř	The la ate ha	Completed					autops perform	ned?	prior to co death? 1 ∐Yes	mpletion of cause of
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5	Physic rathis cral direct	٠ <u>۲</u>	-	R/Outpatien 8b. Time of	t 3 DOA Othe	4 LI Nursing F	lome 5 Reside			y)
NISIOII	th. : Afte	tion	1 Natural 5 Pending (Month, Day, Year) 2 Accident investigation	Injury	Work	yai (? Yes 2∐No	28d. Describe ho	w injury occur	rea	
<u> </u>	r Atter	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home building, etc. (Specify)	e, farm, stre	et, factory, office		28f. Location (St City or Town	reet and Numb	er or Rura	I Route Number,
5	intal or ral Dir led in		Daily, etc. (openly)				Oily of Your	i, Glale)		
:	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	ledical	29a. Certifier  (Check only one)  1 Certifying Physician: To the best of my knowle (2 Medical Examiner: On the basis of examination and manner stated.	edge, death n and/or inv	n occurred at the tirvestigation, in my o	ne, date and place pinion, death occu	e, and due to the c urred at the time, d	ause(s) and m ate and place,	anner as s and due to	stated. the cause(s)
i	To the comp	Me	29b. Signature and title of certifier		29c. License		1	9d. Date signe		Day, Year)
			I freight people as the	,	DY	3371		9(3	0/09	
	3		30. Name and address of person who completed cause of scath Hem 2.	3a) (Type, F	Print) AAM	B 900	or Medi	cal f	Herry	
	Sta	te	Judy Herbert, MD  31. Date file 10 17 17 19 2009 32. Registrar's Signatur	е,	A	imapo	w , will	-		
	Registra		Maria a sava Chang B. B.	park						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ 47A.M Medical Examiner 4a. Facility Name (if not institution), give str and number) 4b. City, Town, or Location of Death 4c. County of Death OCUSON IIMOR If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Yea 1 M 2 KF Months Days Hours Min. 231-21-**Director** Usual Residence of Decedent or 28a-f shov 10a. State within 72 hours after death with the Maryland r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No 10e Street and Number 10g. Citizen of What Country? Funeral 2111 aa 12. Was Decedent Ever in U.S.
Armed Forces
1 Yes 2 No
If Yes, Give
Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 should be filed within 72 hours afte and Mental Hygiene. Is marked other than "natural", 1 Yes 2 No Specify. Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Men Fordans 10/7/ imenium, 21. Signature of Funeral Service License 22. Nam and Address of Facility 16924 VORKED, MONKTON MO 3/11 neval Cha sel REmotionSERVICES Evans 23a. Part 1. Enter the disease, or complications that callsed the death. To not enter the mode of dying, such as cardiac or rispiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Fin-Onset and Death Physician der disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Exami sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

Within 24 hours after death.

To the Funeral Director, Plater this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the burn. P.O. Box 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) ᇛ 1 Yes Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 🕅 Other (Specify) 27. Manner of Deat Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) OCTOBER 2 ZOOG 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month,

670

32. Registrar's Signature

Charles

NOT NOT

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** October 2009 iaam /Medical 4a. Facility Name (If not institution, give street and number) City, Town, or Location of Death 4c. County of Death Examiner **Baltimore City** The Johns Hopkins Hospital 8. Date of Birth (Month, Day, Year) February 23, 2009 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min 1 XM 2 - F Maryland 220-83-1024 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. Count 10c. City, Town or Location 28a-f show Waldorf Charles Maryland 1 ☐ Yes 2 🙀 No per nit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Derartment of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f slamp, injury or other traumatic event, the Medical Examiner must be notified; once. Director 10g. Citizen of What Country? 10f. Zip-Code 20602 10e. Street and Number 12102 Brackenridge Court Funeral Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1x Never Married 2 ☐ Married If Yes, Give Year or Dates 1 Yes 2 No Specify Specify: White <u>\$</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4 or 5+) Elementary/Secondary (0-12) N/A N/A 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Janet M. Rootes Richard C. Sutton, Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 12102 Brackenridge Court Waldorf, Maryland 20602 Richard C. Sutton, Jr. /Father 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date Dulaney Valley Mem. Gardens 10/8/09 1 X Burial 2 Cremation 3 Removal from State Timonium Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a consequence of): LWA disease or condition resulting in death) /Medical **Examiner** Prematunt Extreme Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-transit Due to for as a consequence of) that initiated events resulting in death) Last Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant ☐ Live birth 2 ☐ Fetal death ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) filled in by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 X No 1 Tyes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one, Be examiner? 2 No Other:  $_{4} \square$  Nursing Home 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ this 27. Manner of Death 28a. Date of Injury 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural (Month, Day Year) Injury 5 Pending 2 No 1 Tes investigation 2 Accident after death 3 Suicide Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 - Homicide e Funeral the Hospital 29a. Certifier (check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 🗆 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 aman Registrar's 31. Date filed (Month, Day, State

DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Box 68760,

Division of Vital Records, P.O.

			For State	State of Maryla	,				0000	and the same
90	_	.08	Registrar  1. Decedent's Name (First, Middle, Last,	3	Ce	rtificate of	Death	2. Date of Death	g. No.	3. Time of Death
100 mg	Physici /Medic	_		EENE SPEARS				Month	3, 2009 Year	2:30 P M
	Examin	er	4a. Facility Name (If not institution, give		CENTED		or Location of Death		4c. County of Death	
	Funeral		ROLAND PARK PLACE  5. Social Security Number 6. Sec		rs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	9 Birth	place (State or Foreign
	Director		480 <b>-</b> 30-3407	<sup>3M 2</sup> ₹ 92	Yrs.	Months Days	Hours Min.	(Month, Day, Aug 13,	1917 Iowa	ntry)
111	pui »		Usual Residence of Decedent  10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits
	Aaryla f shov ed at	o	Maryland N/A		Baltimo					1 X Yes 2 No
	the N 28a- notifi	rect	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cou	ntry?
	th with	al D	830 W. 40th Stre	et		2	21211		USA	
	filed within 72 hours after death with the Maryland Hygiene. viter than "natural", or items 23a or 28a-f show ant, the Medical Examiner must be notified at	Funeral Director	11. Marital Status	12. Was Decedent Ever in Armed Forces?	1 U.S. 13.	Was Decedent of H If Yes, specify Cub	Hispanic Origin? (Spoan, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White,	
36	rs afte I', or i	oy Fi	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates:		1 □ Yes 2X No	Specify:		Specify: Whi	Lte
21215-0036	2 hou atura cal E	Completed by	15. Decedent's Edu	ication	16a. Dece	dent's Usual Occup	pation	. 1	6b. Kind of Business/In	dustry
215	thin 7 le. lan "n Medi	nple	(Specify only highest grad	College (1-4or 5+)	life.	DO NOT use retire	,	ing	Universit	17
21	led wi lygien her th nt, the	S	47 E Hada Nama (First Middle Land)		Eng	lish Inst	18. Mother's Nam	o /First Middle N		у
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show way injury or other traumatic event, the Medical Examiner must be notified at once.	o Be	17. Father's Name (First, Middle, Last) Willard	Τ.	Greene		Mazella	,	Ven	ard
JZ Z	2 should and Me is mark aumati	언	19a. Informant's Name/Relationship (Ty	rpe. Print)	19b. Maili	ng Address (Street			City or Town, State, Zi	
≥	1 and 2 Health a em 27 is		Laura E. Perry (	Pers. Rep.)				A, Baltin	nore, MD 21	210
altimore,	Pages 1. nent of He ant: If iten ury or oth		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ F	Removal from State	<ul> <li>Place of Dispo cemetery, cre</li> </ul>	osition (Name of matory or other pla	ice)		0c. Location - City or T	
를	permit. Page Department of Important: If any injury or once.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service bicking	G		nt Cremat		•	altimore,	Maryland
Ba	permii Depar Impor any ir once.		Martin D. Laws	OM	6	500 York	Road, Ba	ltimore,	HOME, INC. Maryland 2	1212
B			23a. Part1. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final						st,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	a. Acute str		t cerebra	al hemisp	nere		3 Days
	Examiner		Constitution of the second of	h -						
	p #	iner	Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a cons	se pience of):					_
	icate be executed physician and s the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a cons	sequence of):					
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ō	Phys r this ral dir	. To	1 Yes 2 No 27. Manner of Death	1 ☐ Inpatient 2	2 ER/Outpatie	III JUDON		ome 5 Reside	nce 6 Other (Spec	ify)
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Division or Vital Records, P.O. Box	l or Attendafter death	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of injury - A building, etc. (Spe	at home, farm, st	reet, factory, office		28f. Location (Str City or Town	eet and Number or Rui , State)	ral Route Number,
	To the Hospital or Attene within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1X Certifying Phy	rsician: To the best of my iner: On the basis of exam	knowledge, dea	th occurred at the t	time, date and place	, and due to the ca	use(s) and manner as	stated.
0	the Hi nin 24 the Fu	ledical	one)	and manner stated.	iniation and/or i					
	To To	Ž	29b. Signature and title of certifier  Jealelle VI	ac grego	en or o		se number 13657		od. Date signed (Month	
ł			30. Name and address of person who c				- '			·
			Isabelle MacGrego	,	, , , , .		Baltimore	Marula	nd 21211	
ľ	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's Si	ignatu e	1	- CAL CAMOL	,	<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. per FH G896 10/13/09 TT State of Maryland 7 Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Rea. No. 101 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** Month Darlene Treston Naomi October 5, 2009 1:00 A /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 310 Ryan Drive Rising Sun Cecil 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Months Days Hours Min. 1 □ M 2 🕱 F Director 62 136-38-0095 5/5/<del>41</del> 1947 Oregon Usual Residence of Decedent Permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" --- any injury or other traumatic exercises. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 TYYes 2 □ No Rising Sun MD Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21911 310 Ryan Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify. <u>م</u> Specify: White 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Government 12 Receptionist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Weiss Franklin Lillian ဂ Kramer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wendy Deaner/ Daughter 162 Huneysuckle Drive, Port Deposit, MD 21904 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatomy Gifts Registry 10/8/2009 | Hanover, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signature Funeral Service Lio 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste.P, Hanover, MD 21076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician aslabe disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 20/2 Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of). Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Month Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate 1 ☐ Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 N/N 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending spital or Attendi nours after death. neral Director: / 2 Accident investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital of within 24 hours at To the Funeral D 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 38 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCT 0 9 2009

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			1 - For State of Maryl Registrar	•	artment of H			iene <sub>eg. No.</sub> 200	9 32450
	Physici /Medio		1. Decedent's Name (First, Middle, Last)				2. Date of Death		
	Examir		4a. Facility Name (If not institution, give street and number) 8800 Walther Blvd. Unit 2110			Location of Death  rkville  If Under 24 Hrs.		4c. County of Do	Balto.
0	Funeral Director		092-18-8299	yrs. last birthday) 7 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, August {	Year)	Birthplace (State or Foreign Country) ew York
15-0036	i within 72 hours after death with the Maryland giene. r than "natural", or items 23a or 28a-f show the "backed Everines rout by nothing at	leted by Funeral Director	10a. State 10b. County 10c.  Md Balto.  10e. Street and Number  8800 Walther Blvd. Unit 21  11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed)	110 n U.S. 13. \	Arkville  10f. Zip Code  2123  Was Decedent of His If Yes, specify Cubar  1 Yes 2 XNo  dent's Usual Occupa kind of work done di DO NOT use retired)	spanic Origin? (Sp n, Mexican, Puerto Specify: Ition	ecify Yes or No- Rican, etc.)	USA  14. Race - Al Black, WI Specify: 1	merican Indian, hite, etc. White
altimore, Maryland 21215-0036	be filed tal Hyg od othe event,	Be Completed	Elementary/Spoendary (0-12)  College (1-4or 5+)  17. Father's Name (First, Middle, Last)  Arthur Tice	HVAC	[echnician	n 18. Mother's Name Elea	e (First, Middle, N	,	C
, Maryl	ss 1 and 2 should be of Health and Menta Item 27 Is marked rother traumatic ev	오	19a. Informant's Name/Relationship (Type. Print) Barry D. Tice Son	1	ng Address (Street a atherstone	nd Number or Rur	al Route Number,	City or Town, State	. , ,
altimore	permit. Pages 1 Department of H Important: If iter any injury or ott		T Bullar 2 Actellation 3 - Helitoval Itolii State	Bayview	sition (Name of natory or other place 2. Name and Address	10-8-	-2009 I	20c. Location - City Balto. Md Funeral Ho	•
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8260, 52	/Medical Examiner  hysician and the prival-transit	dical Examiner	disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Earlier underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a cons	5Mok sequence of):	Ling				
.O. Box 6	the death certification that the attending packed for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pre 1 □ Live birth 2 □ F 4 □ Pregnant at time 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)			23d. Date of o	delivery Day Year
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Vital Records,	n: The law r ificate has bo or, page 2 sh	Completed	25. Was case referred to medical	diony	a fathi	7		prior t death	
Division of Vi	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours after death.  Within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Certification: To Be	examiner?	2 ER/Outpatien 28b. Time of Injury	t 3 DOA Other	4 🗆 Nursing Ho		nce 6 ☐ Other (S	pecify)
D	spital or Atsours after concern after concern Directly filled in by		4 Homicide determined 2ee. Place of Injury - A building, etc. (Sp.)  29a. Certifier 15 Certifying Physician: To the best of my.	ecify) knowledge, death	occurred at the time	e date and place	City or Town,	, State)	Rural Route Number,
	To the Hc within 24 To the Fu completel	Medical	(Check only one)  2 Medical Examiner: On the basis of examiner and manner stated.  29b, Signature and title of certifier	ination and/or inv	vestigation, in my op	inion, death occur	red at the time, da	ate and place, and do	lue to the cause(s)
	\0 Sta	te.	30Name and address of person who completed cause of death in the second of the secon	1) 886	o walt	tu Bl	a) D	arkorllo	Md 21234
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#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **EVELYN** FLORENCE TIRSCHMAN OCTOBER 2009 6:00A M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE FRANKLIN SQUARE HOSPITAL ROSEDALE Social Security Number 216-18-6848 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6-9-1922 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 1 □ M 2**X** F Months Days Hours MARYLAND Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 ☐ Yes 2 No MD BALTIMORE ROSEDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8319 AVERY ROAD 21237 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married 1 □Yes 2X No Specify WHITE Specify: 3€Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) PAINTER WILLIAM MARION ROSE ETHEL (CLARKE) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SHARON TIRSCHMAN/DAUGHTER 17 GILLAND COURT BALTIMORE, MD 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GARDENS OF FAITH 10-10-09 BALTIMORE, Signature of Funeral Service Licensee 22. Name and Address of Facility CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE ROSEDALE, MD

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

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**Funeral** 

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantrian must be notified at once.

Baltimore, Maryland 21215-0036

 Hospital or Attending Physician: The law requires that the death certificate be executed.
 A hours after death.
 Funeral Director: After this certificate has been signed by the attending physician and release in by the funeral director, page 2 should be detached for use as the burial-transit phys attending p icate has been si , page 2 should b

Division of Vital Records, P.O. Box 68760,

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	23a. Part 1. Enter the disease, or comshock, or heart failure. List only	plications that caused the death one cause on each line.	n. Do not enter the mod	e of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
	Immediate Cause (Final disease or condition resulting in death)	a. Uvina	my do	et infer	ton		Onset and Death
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luer	Sequentially list conditions, leaves Enter Underlying Cause (Disease or injury	Due to (of as a consequ	1 1 4	5			
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/IMec	IF FEMALE:	23c. If yes, outcome of pregna	ncv				
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y y	Part II. Other significant conditions	contributing to death but not resu	ulting in the underlying ca	use given in Part I.	23e. Did tobacc	o use contribute to	o the cause of death?
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completed					24a. Was an autopsy performed;	prior to death?	utopsy findings available completion of cause of
מ	25. Was case referred to medical examiner?			26. Place of Dea	th (Check only one)		
0	1 Yes 2 XNo		ER/Outpatient 3 DO	A Other: 4 ☐ Nursing H	ome 5 ☐ Residence	6 ☐ Other (Spe	ecify)
990	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of 2 Injury M	3c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred	
Cel unicaudii. I	3 Suicide 6 Could not b 4 Homicide determined		me, farm, street, factory,	office	28f. Location (Street City or Town, Sta	and Number or R ate)	ural Route Number,
calcal	29a. Certifier (Check only one)  1 Certifying Pt 2 Medical Exam	nysician: To the best of my kno- miner: On the basis of examina and manner stated.	wledge, death occurred tion and/or investigation	at the time, date and place in my opinion, death occu	r, and due to the cause rred at the time, date a	e(s) and manner a and place, and du	is stated. e to the cause(s)
INIC	29b. Signature and title of certifier	M.D		D 00551'7		Date signed (Mon	
	30. Name and address of person who Sebastian K	completed cause of death (Item		Arenne	Boltima	e Mo	21224

State

Registrar

Sebastion K John

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31. Date filed (Month, Day, Year)

32. Registrar's Signature

Amend #30 per DVR g896 10/9/09 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. (1) 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2009 ear OCT. **Physician** Frank C. Tate 6 UCO /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Rosedale

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 10,1922 9118 Baldridge Way Baltimore Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 215-18-7107 1 XM 2 □ F 87 Yrs. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Manyland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mexical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Rosedale 1 ☐ Yes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9118 Baldridge Way 21237 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ Malo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bus Driver Lincoln Trans Co. 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be George Knott Anna Firmwalt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Tate / wife 9118 Baldridge Way Baltimore MD 21237 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Holly Hill Cemetery 10/10/09 Baltimore MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility  $300\,$  Mace Ave. Balto. MD Funeral Service Licensee Connelly Funeral Home of Essex 21221 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the tieath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical s a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Box 68760, The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical attending phy IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 4□Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 1 ☐ Yes 2 ☐ No. Division or Vital Records, P.O. 9 Unknown signed by the detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has le 2 autopsy s certificate has lirector, page 2 performed' 1 ☐ Yes 2 ☐ No 1□ Yes 2□ No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 2 this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural Injury 5 ☐ Pending investigation neral Director: A filled in by the fu M 1 ☐ Yes 2 ☐ No deat 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined af er 4 Homicide Hospital within 24 hours a

To the Funeral I

completely filled 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 38048 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Howard Goldman, MD 9106 Philadelphia Rd., Suite 304, Baltimore, MD 21237

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

OCT 0 9 2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician Month Year 11.35 A M 10 05 2009 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MORIAL 123 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 💢 F Months Days Hours Min. 228-36-7753 Director MAKCH 15.1932 Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If Hean 27 is marked other than "natural", or items 23a or 28a-1 show any Injury or other traumatic event, it a Maritea Exonities mant be notified at Director 1 XYes 2 □ No ALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 16,5.A Funeral 1030 E 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 □Yes 2√€ No Specify: <u>S</u> 3 Widowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1215 CLOTHENS MANUSTE 2425 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ EXANCER ANG/09 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) anta MD. 31237 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Wead LAWN. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hetricea CAROLINE ST. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) days Physician Respiratory Distress Acute Syndrome /Medical Due to (or as a consequence of): Examiner Preumonia weeks Legionella Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Acidosi. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed Acute 24b. Were autopsy findings available prior to completion of cause of death? Renal 24a. Was an autopsy performed? Yes 2 No 2 No 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 ☐ Accident investigation 1 ☐Yes 2 ☐No 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed Box 68760, Records, P.O. Division of Vital

within 24 hours after deaun.

To the Funeral Director: Af To the

> State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

MOZAYAN. M.D. Union Memorial Hospital 31. Date filed (Month, Day, Year)

MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DANOS

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

AT-2438946-B7

29d. Date signed (Month, Day, Year)

10/5/2009

MD

Baltimore

<b>\</b>			. For	State of Man	/land / Dep	artment of F	lealth and Me	ntal Hygien	e) () ()	00100
		•	1 - State Registrar			rtificate of		Reg. N	LUUT	021302
	Physici	an	1. Decedent's Name (First, Middle, L		11.6	1	2.	Date of Death Month D	ay Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, g	JOSEPH	VAL	AN COL	or Location of Death	10	7 2009 c. County of Death	1135 AM
	Examin	er	À	LL CEWITR		10	IMURE	1	BATIMO	NE
	Funeral			Sex 7. Age (II	n yrs. last birthday,	1011-1	1771010	Date of Birth (Month, Day, Year	9. Birthr	place (State or Foreign
	Director		021-20-0176	127 M 2□F	3 Yrs.	Worldis Days	Trouis IVIII.	_ /	26 New	Jersey
	and and		Usual Residence of Decedent  10a. State 10b. County	10	c. City, Town or L	ocation				10d. Inside City Limits
	Many -1 sho	tor	MARNIANA BA	LTIMORE	BALTI	MORE				1 Yes 2 No
	th the	Director	10e. Street and Number			10f. Zip Code			itizen of What Cou	ntry?
	ath wi	ral	8710 Em			212			JSA	
	ter de	Funeral	11. Marital Status 1 ☐ Never Married 2 ☑ Married	12. Was Decedent Eve Armed Forces?			Hispanic Origin? (Specif an, Mexican, Puerto Ric	ean, etc.)	14. Race - Ameri Black, White,	
920	urs aff	by	3 Widowed 4 Divorced	1 □Yes 2 □ No If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify: Whi	te
215-0036	within 72 hours after death with the Maryland ene. then "netural", or items 23a or 28e-f show ta Medical Exertiner must be notified at	Completed	15. Decedent's (Specify only highest g	Education trade completed)	(Give	edent's Usual Occup kind of work done	during most of working	16b.	Kind of Business/In	
121	vithin ne. hen "	mpie	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	(d)		inting Co	
d 21	filed v Hygie other t		12 17. Father's Name (First, Middle, Las	st)	Owne	er / Opera	ator 18. Mother's Name (F		inting Co on Surmarne)	mparry
an	lid be lental ked o	To Be	Albano (nmn) Va				Angelina	(nmn)	Tarara	
Maryland	2 should be and Mental Is marked of aumetic eve		19a. Informant's Name/Relationship	(Type, Print)			and Number or Rural F			
-	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "netural", or items 23e or 28e-f show any injury or other traumetic event, II a Medical Examinar must be notified at ance.		Aulie C. Valanzo				Lane Apt. 3			
more	Pages 1 nent of H ant: If ite		20a. Method of Disposition  1 Burial 2 Cremation 3	Hemoval from State		osition (Name of matory or other pla	}		Location - City or T	
=	iit. Pa artmer ortent injury t.		' 4 □ Donation 1 5 □ Other (Spec	city)	- At.		orp.   10-8-0		wson, Mar	ryland
Bal	permit. Departr Importe any inju		Marlesam	up //		McComas 1	ess of Facility Funeral Hon esbury Road	me, P.A.	on Marvl	and 21009
			23a. Part1. Enter the disease, or co shock, or heart failure. List of	replications that caused the	e death. Do not en	iter the mode of dyi	ng, such as cardiac or r	espiratory arrest,	OII PHALY	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	0	OWARY	EDEMA				Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a c						
	Examine:	-	Sequentially list conditions,	b. CONCE	STIVE ON SEQUENCE OF ITS	HEART	FAILURE			
	uted	Examiner	any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C0804	ARV A	0168V	PISENSE			
o,	te be executed ysician and ie burial-transit	Exa	resulting in death) Last	Due to (or as a c	onsequence of):	N. L.				
8760	¥ × 0	licai		d						
x 68	The taw requires that the death certifica ate hes been signed by the attending ph page 2 should be detached for use as it	Physician/Med	IF FEMALE:	23c. If yes, outcome of	pregnancy				23d. Date of deliv	ven/
Вох	atten I for u	cian	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live birth 2 [ 4 Pregnant at tim	Fetal death 3	☐Ectopic pregnanc ☐ Other (specify) _	y		Month Month	Day Year
P.O.	t the d by the achec	hysi	9 Unknown	9□ Unknown				5		
	ires that the death cert signed by the attendin d be detached for use	by P	Part II. Other significant conditions	contributing to death but r	not resulting in the	underlying cause gr	ven in Part I.		_	the cause of death?
Records,	w require been si should t							1 🗆 Yes		bably 4 □Unknown
ě	hes b	Completed						24a. Was an autopsy performed?	prior to co	opsy findings available ompletion of cause of
alF	n: Th ficate rr, pag		OF Man area ortered to madical					1□ Yes 2x		2 No
Vital	Physician: this certificatal director,	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1   Inpatient	2 ER/Outpatie	ent 3 DOA Ott	26. Place of Death ( her: 4 • ursing Home		6 □Other (Spec	ifv)
J of	ig Phy ter this		27. Manner of Death	28a. Date of Injury (Month, Day Y	28b. Time			d. Describe how in		,
Jivision	endin sath. or: Af he fur	Certification;	1 ♠ Natural 5 ☐ Pending 2 ☐ Accident investigat	ion		M 1	Yes 2 □ No			
<u>Ş</u>	I or Attendi after death. Director: A I in by the fu	rtific	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	building, etc. (			28	f. Location (Street City or Town, Sta	and Number or Rui ite)	ral Route Number,
	poltal cours a leral D		29a. Certifier Certifying	YING WURSE	PRACTITI		ime, date and place, an	o que io ine cause	(ร) สมดี เมลเเมษา สร	Slateu.
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	edicai		aminer: On the basis of example and manner stated	amination and/or is					
	To th Withir To th comp	Me	29b. Signature and title of certifier	,		29c. Licen	se number	29d. [	Date signed (Month	, Day, Year)
			May 1.	What NU	RSE PRAC	TITILLER	AC 00026	2 1	0/7/200	79
			30. Name and addra s if person wh	o completed cause of deal	h (Item 23a) (Tybe	Printi				1
	Sta	ato.	31. Date filed (Month, Day, Year)	32. Registrar's	310 C	HICKORY	WAY N	EWARK,	VE 1774	/
	Regist			2009 anous	J. J.	ankal	WRY N			

			For	State of Mary		epartment of F		d Mental Hy	giene			
			State Registrar			Certificate of	Death	2. Date of Dea	Reg. No.	C	3. Time of D	and the
	Physicia /Medic		1. Decedent's Name (First, Middle Mabel		aver			Month 18	Day		3.11110	)A <sup>M</sup>
	Examin		4a. Facility Name (If not institution	n, give street and number)		4b. City, Town, o	r Location of D	eath	4c. Count			
1	Funeral		5. Social Security Number	6. Sex 7. Age (In	yrs. last birt	hday) If Under 1 Year	If Under 24		th	9. Birthr	place (State or i	Foreign
	Funeral Director		217-40-3639	1 □ M 2 <b>/□X</b> F	68	/rs. Months Days	Hours N	1in. (Month, Da 7 9	1941	Coui	NC	
$\leq$	pul »		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town	or Location					10d. Inside City	/ Limits
0	the Marylar 28a-f show	tor	MD 100. Godiny		Balti						1 <b>X</b> Yes 2	2□No
$\mathcal{Q}$	r 28a-	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Cou	ntry?	
$\leq$	th with	ralD	1700 Meride	ene Drive		212				SA		
439	er dea items	Funeral	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S.	13. Was Decedent of H If Yes, specify Cub	lispanic Origin' an, Mexican, P	? (Specify Yes or No uerto Rican, etc.)	14. Ra	ice - Ameri ack, White,	ican Indian, etc.	
$\sim$	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Medical Examiner mast be multied at	by	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	If Yes, Give 4		1 □ Yes 2√√ No	Specify:		Speci	fy: Bl	.ack	
2-0036	72 hou	Completed	15. Deceden	t's Education st grade completed)	16a.	Decedent's Usual Occup (Give kind of work done	oation during most of	working	16b. Kind of E	3usiness/In	idustry	
7/2	vithin in the in the interest	Jd m	Elementary/Secondary (0-12)	College (1-4or 5+)	Ε	Give kind of work done life. DO NOT use retire is abled	d) _	_	N	I/A		
425	filed v Hygic other t	Be Co	12th 17. Father's Name (First, Middle,	Last)		<del></del>	18. Mother's	Name (First, Middle	, Maiden Surna	me)	-	
AAC aryland	Jid be Jental rked c tic ev	P P	Tony	Edwards				voina	Pear			
	2 shou and ∯ is ma auma		19a. Informant's Name/Relations	hip (Type. Print)	1	Mailing Address (Street						
< ≥	l and lealth		Senora Walte	ers-daughter		18 Weyfiel		Balt1mo	20c. Location		L237	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mertial Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ire Medical Examiner must be notified at once.		1  Burial 2 ☐ Cremation	3 Li Removal from State	Garde	Disposition (Name of y, crematory or other pla en of Fait	<i>се)</i> :h : 1 (	0/10/09		•	ce Co.	MD
ij	nit. Paratme ortani injury		4 ☐ Donation 5 ☐ Other (S	pecity)		22. Name and Addre	ess of Facility	MARCH F	UNERAI	HOM	IE-EAS	T
ä	Dep Imp any		> Blan	dus Wa	me			Avenue		ore,	MD 2.	1202
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused the only one cause on each line.	death. Do r	not enter the mode of dyi	ing, such as ca	rdiac or respiratory a	arrest,		Approximate Interval Betw Onset and De	veen
Jan San	Physician		Immediate Cause (Final disease or condition resulting in death)	SEPS	15	AND F	1KU.	5		$\rightarrow$		
	/Medical Examiner			Due to (or as a co	nsequence of	) () ()						
		ner	Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a co	insequence (	of).		TIC	TIL	0		
6	ecutec and transit	Examiner	Cause: (Disease or injury that initiated events resulting in death) Last	c. COLO	<u>~ ()</u>	JIHIE	WE	D F15	100	7		
<sup>\_</sup> 09	ficate be executed physician and s the burial-transit	a E	resulting in deathy East	Due to (or as a co	insequence (	JI).						
68760,	tificate ng phys as the	edical		d								
Вох	Attending Physiclan: The law requires that the death certif refeath. ector: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of p		3 ☐ Ectopic pregnan	cv			Date of delivery	-	/ear
	the att	sicis	in the past 12 months? 1 ☐ Yes 2 ☐ N 9 ☐ Unknown	4 ☐ Pregnant at tim 9 ☐ Unknown		5 ☐ Other (specify)			"	nonui	Day	Cui
P.O.	res that the de signed by the be detached	Ph	Part II. Other significant conditi	ons contributing to death but no	ot resulting ir	the underlying cause gi	ven in Part I.	23e. Did	tobacco use co	ntribute to	the cause of de	eath?
rds,	puires tha n signed Ild be det	d by						1□	Yes 2 No	3 □ Pro	obably 4 □ U	Jnknown
Division of Vital Records,	ysiclan: The law requii nis certificate has been s director, page 2 should	Completed						24a. Was		. Were aut	topsy findings a	available ause of
B.	The laste has page	Com						perf 1 □Yes	ormed?	death?	2 N	
Vita	iclan: Th certificate ector, pag	Be (	25. Was case referred to medica examiner?	Hognital:		Ot	hor:	Death (Check only				
of	ling Phys	.To	1 Yes 2 DW 27. Mann⇒ f Death	28a. Date of Injury	28b.	Time of 28c. Inju	4 □ Nurs	ing Home 5 ☐ Res 28d. Describe	how injury occ		sify)	
io	nding ath. r. Afte ee fune	atior	E LI Accident	igation	ear) I		ork? ∐Yes 2. ☐No					
i.s	ir Atte ter dei irecto	Certification: To	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deterr	not be nined 28e. Place of Injury - building, etc. (S	- At home, fa Specify)	rm, street, factory, office			(Street and Nur wn, State)	nber or Ru	ıral Route Numl	ber,
۵	pital c		29a. Certifier 1 Certifyi	ng Physician: To the best of m	ny knowledge	e death occurred at the	time date and	place, and due to the	e cause(s) and	manner as	s stated.	
	To the Hospital or Attending Physimitin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral di	Medical	(Check only 2 Medical one)	Examiner: On the basis of examiner stated	amination ar	nd/or investigation, in my	opinion, death	occurred at the time	e, date and plac	e, and due	to the cause(s)	)
K	To the vithir To the Comp	Me	29b. Signature and title of certific	<u>r</u>		29c. Licen	nse number		29d. Date sig	ned (Month	n, Day, Year)	7,
	•		1. didul	19 MEDICAI	L-RE	MENT	KES	UOO	10,1	181	2000	1 _
			30. Name and address of perser	who completed cause of death	h (Item 23a)	(Type, Print)	Paul	An Bh	10 B	414	2100	39
	Str	ate	31. Date filed (Month, Day, Year	) 32. Registrars	Signature		MIN		v I	1/4	$X/\propto$	J_1_
	Regist		OCT NO 26	109 August	A. 1	arko						

			For State Registrar	ite of Maryland		rtment of He tificate of D			ene g. No. 🤿 🍴 🖺 🔘	501.61
	Physicia		Decedent's Name (First, Middle, Last)					Date of Death     Month	Dav Year	3. Time of Death
	/Medic	_	Katherine Rice Will					October	6, 2009 4c. County of Deatl	11:30 PM
	Examin	er	4a. Facility Name (If not institution, give street 709 Maiden Choice L			4b. City, Town, or Catons			Baltimore	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last	birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9. Birth	nplace (State or Foreign
Н	Director		212-12-1112	<sup>⊠</sup> 95	Yrs.	Months Days	Hours Min.	Aug. 1,	1914 Vir	ginia
	pug 💉		Usual Residence of Decedent  10a, State 10b, County	10c. City, T	own or Loc	cation				10d. Inside City Limits
	Manyla f sho	lor	MD Baltimore		Cator	nsville				1 ☐ Yes 2 🛣 No
	r 28a-	Director	10e. Street and Number		04.001	10f. Zip Code		10	g. Citizen of What Co	untry?
	th with 23a o 1st be		709 Maiden Choice La	ne RG425		212			USA	
21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Funeral	1 Never Married 2 Married 1 If	as Decedent Ever in U.S. med Forces? Yes 2 X No Yes, Give ar or Dates:		Vas Decedent of Hir f Yes, spedfy Cubar ☐ Yes 2 █ <b>XN</b> o	spanic Origin? (Sp n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: WI	
2-0	72 ho 'natur dical I	eted	15. Decedent's Education (Specify only highest grade com		(Give	ent's Usual Occupa	lurina most of work	ing	16b. Kind of Business/	Industry
121	vithin ane. than "	Completed		ollege (1-4or 5+)		00 NOT use retired, Feacher	)		Education	2
d 2	filed v Hygie ther t		17. Father's Name (First, Middle, Last)				18. Mother's Name	e (First, Middle, M		
lan	lid be lental <b>ked</b> o	To Be	Robert Russell Rice				Anne El	lizabeth	Scott	
Maryland	2 shou and N is mai		19a. Informant's Name/Relationship (Type. Pr	int)	19b. Mailin	g Address (Street a	and Number or Rui	al Route Number	City or Town, State, 2	Zip Code)
≥, ≤	and 2 lealth m 27 i		Homer L. Riggins, III			Vessling sition (Name of			11e, MD 212	
altimore,	Pages 1 a nent of Hee ant: If Item ury or othe		20a. Method of Disposition  1 ☒ Burial 2 ☐ Cremation 3 ☐ Remov  4 ☐ Donation 5 ☐ Other (Specify)	al from State Rappa	etery, cren hanno h. Cor	natory or other place ock Chris	tian 10/	12/09 T	appahonnocl	k, VA
Balt	permit. Pages Department of Important: If It any Injury or o		21. Fign iture of Funeral Service Licensee	suglet	_   Fu	Name and Address uneral Ho 530 Edmon	ss of FacilitySter me of Car dson Aver	rling As tonsvill nue; Cat	hton Schwal e, Inc. onsville, I	MD 21228
	*		23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	ise on each line. 🔼	Do not ent	er the mode of dyin				Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition	150	ecu	10119				Oliset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequer	nce of):					
		e.	Sequentially list conditions, if any, leading to immediate cause. It is not not him to Cause, (Disease or injury	Due to (or as a consequer	nce of):					
	uted d ansit	Examiner	that initiated events c.							
0,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a consequer	nce of):					
68760,	ate by	edical	d							
.O. Box 6	death certif e attending d for use a	Physician/Me	in the past 12 months?	yes, outcome pf pregnanc □Live birth 2 □ Fetal de □ Pregnant at tim <i>e</i> of dea □ Unknown	eath 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	livery Day Year
<u>α</u>	juires that the de n signed by the a lid be detached i	þ	Part II. Other significant conditions contribute	ing to death but not resulti	ng in the u	nderlying cause give	en in Part I.	23e. Did to	bacco use contribute to	o the cause of death?
Il Records,	ician: The law requires that the certificate has been signed by the rector, page 2 should be detache	Completed						24a. Was a autops perfor	sy prior to med2 death?	utopsy findings available completion of cause of
Vital	Physician: The rithis certificate ral director, pag	Be	25. Was case referred to medical examiner?	al:	2/2	ot acinos Othe	or:	th Check onl or		
9	Phys or this eral dir	<u>ا:</u>	1 162 5 1040	a. Date of Injury 2	8b. Time o	I 3 DOA	4 Nursing H		ence 6 Other (Spe ow injury occurred	ecify)
ion	Attending Ir death.  ector: After by the funer	ation	1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Injury		K? Yes 2 □ No			
Division	n are to	Certification:	3 Suicide 6 Could not be determined 28	e. Place of injury - At hom- building, etc. (Specify)	e, farm, str	eet, factory, office		28f. Location (S City or Tow	treet and Number or R n, State)	ural Route Number,
	To the Hospital or Attenwithin 24 hours after death To the Funeral Director: completely filled in by the	Medical C	(Check only 2 Medical Examiner:	n: To the best of my knowl on the basis of examination	edge, deat on and/or in	h occurred at the tire vestigation, in my o	me, date and place	, and due to the d rred at the time, d	cause(s) and manner a date and place, and du	s stated. e to the cause(s)
	To the To the To the To the Comple	Me	29b. Signature and title of certifier	,		29c. Licens	e number	2	29d. Date signed (Mon	th, Day, Year)
			<b>)</b>	/ my		60	2018		October 7	, 200 4
			30. Name and address of person who comple	ted cause of death (Item 2	(3a) (Type,	Print)	a la	0 C	ghu V	ing
	St Regist	ate rar	31. Date filed (Month, Day, Year)  OCT 0 9 2009	32. Pegistrar's Signatu	9. A	arked				

State of Maryland / Department of Health and Mental Hygiene

			For State Of Wal yial   State Registrar		rtificate of L			g. No. 200	9 32465
	Physicia	an	1. Decedent's Name (First, Middle, Last)				Date of Death     Month		3. Time of Death
	/Medic	al	LEROY HERBERT WHITEHE	AD		1	OCTOBER	7, 2009 Ye a	
	Examin	er	4a. Facility Name (If not institution, give street and number)  1431 B Knopp Road		4b. City, Town, or Jarrett:			Harfor	
***	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	if Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. E	Birthplace (State or Foreign Country)
	Director		213-26-3546   ¹™ 2□F   78	Yrs.	Montals Days	Tiours Willin	Apr. 20		Maryland
	ow m		Usual Residence of Decedent           10a. State         10b. County         10c. Cit	y, Town or Lo	ocation				10d. Inside City Limits
	a-fsh	ctor	Maryland Harford J	arrett	sville				1 □Yes 2 📉 No
	or 28	Dire	10e. Street and Number		10f. Zip Code		10	g. Citizen of What	Country?
	s 23a	eral	1431 B Knopp Road	0 40	21084	0.1-1-0.70		USA	and an Indian
	fter de ritem iner	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  1. Was Decedent Ever in U. Armed Forces?  1. ▼Yes 2 □ No	i i	Was Decedent of His If Yes, specify Cubar		Rican, etc.)	Black, WI	merican Indian, hite, etc.
ğ	ral", o	d by	3 ☐ Widowed 4 ☐ Divorced If Tes, Give Year or Dates:		1 □Yes 2 XNo	Specify:		Specify:	White
21215-0036	is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hyglene. It health and Mental Hyglene item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, It a Marical Examinar must be notified at	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Dece (Give	dent's Usual Occupa kind of work done d DO NOT use retired)	ation Juring most of work	ing 1	16b. Kind of Busines	ss/Industry
121	within ene. than '	duic	Elementary/Secondary (0-12) College (1-4or 5+)		at Managei			Grocers	y Retail
	if Hygi other ent, I	Be Co	17. Father's Name (First, Middle, Last)			18. Mother's Name	e (First, Middle, M		TUCCLE
Maryland	should be and Menta s marked umatic ev	TO B	Herbert Leroy Whitehead	_		Thelma	Mary Lau	cht	
ar)	2 sho and is ma rauma		19a. Informant's Name/Relationship (Type. Print)	1	ng Address (Street a			-	
	1 and Health em 27 ther t		Sandy L. Barber / Daughter  20a. Method of Disposition 20b. F					ville, Mai	ryland, 21084
Baltimore,	Pages nent of int: If its iry or o		I KU BURAL 2 L. Cremation 3 L. Removal from State		osition (Name of matory or other place	i			
Ħ	permit. Pages Department of Important: If it any Injury or o		21. Signature of Fune of Service Licensee		MEMOTIAL  2. Name and Addres			rallston, uneral Ho	, Maryland
ñ	lmp any		Markelling !		50 W. Bro			Maryland	
			23a. Part 1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.	h. Do not en	ter the mode of dying	g, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)  a. Colon		ncer	•			Onset and Death
	/Medical Examiner		Due to (or as a conseq	uence of):					
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	uence of):					
	icate be executed physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence)						
Ď,	be execian a	E	resulting in death) Last Due to (or as a conseq	uence of):					
68760,	physi physi the b	dice	d						
ROX	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnant					23d, Date of	delivery
	death ne atte	sicia	in the past 12 months?  1  Yes 2 No  1  I le proven		☐ Ectopic pregnancy ☐ Other (specify)	′		Month	Day Year
J.	at the d by th etache	Phys	9 Li Unknown		. 4. 4 *		OO- Dida-b		a to the equipment death?
ďŠ,	w requires that the de been signed by the should be detached	by	Part II. Other significant conditions contributing to death but not res	uiting in the u	nderlying cause give	en in Part I.		s 2 No 3	e to the cause of death?  Probably 4 Diknown
Hecords,	v requ	Completed	The transfer of the transfer o				24a. Was an		autopsy findings available
Ě	The lav ate has page 2	duic					autopsy perform	v prior	to completion of cause of
VIta	slcian: The law certificate has the rector, page 2 s	Be C	25. Was case referred to medical			26. Place of Deat			′es 2□No
	Attending Physician: or death. ector: After this certific. by the funeral director, I	일	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2	ER/Outpatie	nt 3 □ DOA Othe	er: 4 🗆 Nursing Ho	me 5 Reside	nce 6 Other (S	pecify)
DIVISION OF	· Attending Physer death. rector: After this by the funeral di	ion:	27. Manner of Death 1 Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year)	28b. Time o Injury	Work	?	28d. Describe ho	w injury occurred	
<u> </u>	Attendi death. ctor: / y the fu	ficat	2 Accident investigation 3 Suicide 6 Could not be 28e Place of Injury - At h	ome, farm, st	1.	res 2□No	28f. Location (Str	reet and Number or	Rural Route Number,
2	al or / s after il Dire	Certification:	4 Homicide determined 28e. Place of Injury - At he building, etc. (Special	<i>(y)</i>	,,		City or Town	, State)	, , , , , , , , , , , , , , , , , , , ,
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier (Check only (Ch						
	the H hin 24 the F mplete	Medical	one) and manner stated.	tion and/or ii					
	<b>5</b>		29b. Signature and http://certifier		29c. License	number	2	9d. Date signed (Mo	
			30. Name and address of person who completed cause of death (Iter	n 23a) (Tvne	Print)	014	)	10/07	12001
			Karl Spector, MD 2	214 To	llgate R	oad B	sel Air	mo.	21015
	Sta		31. Date filed (Month, Day, Year) 32, Registrar's Signal (Month, Day, Year) 32, Registrar's Signal (Month) 32, Registrar's S	iture A	a Kad				
	Registr	alr	APLA CARA VIENCE						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Margaret W. Wilhelm 2009 P.M October Medical 4a, Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Gilchrist Hospice Baltimore County TOWSON 9. Birthplace (State or Foreign Country)
Baltimore, MD. 8. Date of Birth
(Month, Day, Year)
April 17.1919 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F Hours Director 220-07-0061 90 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛅 No Maryland Baltimore County Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8645 Ouentin Ave. 21234 United States 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11 Marital Status 1 Never Married 2 Married Completed by ☐ Yes 2X No Maryland 21215-0036 1 ☐ Yes 24 No Specify: If Yes. Give Specify: White 3 ☑ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A Bank Teller Banking Be 17. Father's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) Richard Adolphus Miller, Jr. Elizabeth Juanita Wheeler 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Linda Marie Wilhelm (Daughter) 8645 Quentin Ave. Baltimore, Maryland 21234 Baltimore, Date 08, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite cemetery, crematory or other place)

Evans Funeral Chapel Oct. 2009 è 1 Burial 2 Cremation 3 Removal from State injury o Forest Hill, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr., P.A.
2325 York Road Timonium, Maryland 21093 žu complications only one cause 23a. Part 1 Enter the disease shock or heart failure. List Immediate Cause (Final disease or condition resulting in death) Approximate Interval Between Onset and Death that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Physician Complications iosarcoma Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to for as a consequence of if any leading to immedi-cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 Vo ō Year Month Day Pregnant at time of death 5 Other (specify) been signed by the a should be detached f 1 Yes 2 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ UILHELM, MARGARET Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Gilchast Ho 2 💢 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 1.XNatural 5 Pending 2 Accident
3 Suícide 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) R149194 October 7, 2009

Registrar
DHMH 17 Rev 7/2009

State

MD

lowson

21204

N. Chales

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701

Grant

31. Date filed (Month\_

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** h'Mus 26 thio 100 . OD | M 0 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Fairhaven Wellness Center Sykesville Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday **Funeral** Months Days Hours Min. 1**½** M 2□ F 212 01 7953 7/18/1912 Director MD Usual Residence of Decedent Maryland 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or Items 23a or 28a-f show Examiner must be notified at 1 ☐Yes 2 No Director MD Howard Ellicott City the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11390 Frederick Rd. 21042 USA Funeral Pages 1 and 2 should be filed within 72 hours after death vment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 233 ury or other traumatic event, the Medical Experimental ury or other returnatic event, the Medical Experiment return. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. White Completed by Specify: 3X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Drydock Worker Shipping / Receiving 17. Father's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Surname) Be Thomas Foley Pattison Clara V. Cole ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11394 Frederick Rd., Ellicott City, MD 21042

ace of Disposition (Name of Date 20c. Location - City or Town, State Carolyn Deverin / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of H Important: If ite any Injury or of once. 1 Burial 2 □ Cremation 3 □ Removal from State Christ Church Cemet. 10/1/2009 Columbia, MD 4 □ Donation 5 □ Other (Specify) 21. Signat of Funeral Service Licensee M01411 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. ast 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last onsequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.O. I ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 1 □ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier EcritifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year)

10

State Registrar Name and addres

of person

31. Date filed (Month, Day, Year)

SEP 2 8 2009

32. Pegistrar's Signature

32. gegistrar's Signature

Drews B. Sarks

completed cause of death (Item 23a) (Type.

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se	Type or Print in Black in	idelible ink.	Ensure All	Copies Are	Legi
	Ctata of Maruland / Dan	artment of H	nalth and Ma	otal Hyaiaa	^

		. Togica and	ertment of Health and Nertificate of Death	Reg. No.	119,32168
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Millard Curtis Ayers, Jr.			3. Time of Death 7:02 A M
Examino	er	4a. Facility Name (If not institution, give street and number)  Caroline Home for Hospice  5. Social Security Number   6. Sex   7. Age (In vrs. last birthda)	4b. City, Town, or Location of Death  Denton  If Under 1 Year   If Under 24 Hrs.		of Death oline 9. Birthplace (State or Foreign
Funeral Director		5. Social Security Number  228-42-3656  Usual Residence of Decedent  6. Sex  7. Age (In yrs. last birthday 77 Yrs.	Months Days Hours Min.	Mar. 3, 1932	Virginia
th the Maryland or 28a-f show	Director	10e. Street and Number	Gocation Federalsburg 10f. Zip Code	10g. Citizen of V	10d. Inside City Limits 1 ☐ Yes 2 ☑ No What Country?
permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, if a Medical Examination to other traumatic event even	by Funeral [	6944 Reliance Road   11. Marital Status   12. Was Decedent Ever in U.S. Armed Forces?   1	21632  Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2□No Specify:		d States e-American Indian, k, White, etc. :: White
led within 72 hou lygiene. her than "natura nt, tre Medical E	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+) 11 (Grad.)  16a. Dec (Giv (iit))  College (1-4or 5+) 0 w n o	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) er of Ayers Elec	t. Svc. Electr	
should be fil nd Mental H marked ot Imatic ever	To Be	17. Father's Name (First, Middle, Last)  Millard Curtis Ayers, Sr.  19a. Informant's Name/Relationship (Type. Print)  19b. Mai		e (First, Middle, Maiden Surnam irginia Shie] ral Route Number, City or Town,	lds
Pages 1 and 2 and 2 and of Health a nert; If item 27 is iry or other trau		20a. Method of Disposition 20b. Place of Disposition	A Reliance Rd.,  consition (Name of paralloly or other place) Sh. Veterans 10/	Date 20c. Location -	City or Town, State
permit. Departrimporta Importa any Inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility Fra 216 N. Main St., Fe	amptom Funera	al Home, P.A
Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Unidentlying Cause (Disease or injury that initiated events	nter the mode of dying, such as cardiac	or respiratory arrest,	Approximate Interval Between Onset and Death Days Years Years
hat the death certificate be to by the attending physici detached for use as the bu	Physician/Medical	Due to (or as a consequence of):  d.  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 □ Live birth 2 □ Fetal death 3	☐ Ectopic pregnancy ☐ Other (specify) underlying cause given in Part I.	Mo	te of delivery onth Day Ye ar ribute to the cause of death?
sician: The law requir certificate has been s rector, page 2 should	Completed by			24a. Was an autopsy performed? 1 □ Yes 2 No	Were autopsy findings available prior to completion of cause of death?
tending Physicia eath. or: After this certi the funeral directo	Certification: To Be	25. Was case referred to medical examiner?  1	th (Check only one) ome 5 ☐ Residence 6 🗷 Oth 28d. Describe how injury occuri		
To the Hospital or Attend within 24 hours after death To the Funeral Director , completely filled in by the f	Medical Certific	3 ☐ Suicide 4 ☐ Homicide  29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, de and manner stated.	ath occurred at the time, date and place		anner as stated.
To the within To the comply	Me	29b. Signature and title of certifier	29c. License number 3057749	STATE 1	d (Month, Day, Year)
Stat Registra	_	30. Name and address of person who completed cause of death (Item 23a) (Type Li Vaid yana+han, MD, 2195. W  31. Date filed (Month, Day, Year)  SEP 29 2009		ton. MD 2160	)1

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	-	State of Maryla		ertment of H Stificate of L		Reg	ene g. No. 💚 🎧 🕦 🖸	32469
Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Fortunato Barbieri				2. Date of Death Month September	23, 2009 <sup>Year</sup>	3. Time of Death 1:45 p M
Examin Funeral	er	4a. Facility Name ( <i>If not institution, give street and number</i> )  10033 Dallas Avenue  5. Social Security Number  579-58-1754  6. Sex  1★ M 2□ F  10	s. last birthday) Yrs.		Spring If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, April 22	9. Birt	n gomery hplace (State or Foreign untry) Italy
show show	or	Usual Residence of Decedent  10a. State 10b. County 10c. 0	City, Town or Lo			APITI 22	2,1900	10d. Inside City Limits 1 ☐ Yes 2 ☒ No
with the M 3a or 28a-f	al Director	Maryland Montgomery  10e. Street and Number  10033 Dallas Avenue	511	ver Sprin	<u>ıg</u>	10	g. Citizen of What Co	untry?
partimore, Interview A 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Medical Expriner, must be Incilined at once.	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ※ Widowed 4 □ Divorced  12. Was Decedent Ever in Armed Forces?  1 □ Yes 2 ※ No If Yes, Give Ye ar or Dates:		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 □•No	ispanic Origin? (Sp an, Mexican, Puerto Specify:		14. Race - Ame Black, White Specify: Wh	e, etc. ite
Z I Z I 5-0U30 d within 72 hours aft giene. er than "natural", or fre Medien Esseri	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give	dent's Usual Occup kind of work done o DO NOT use retired Handyman	during most of work	vorking 16b. Kind of Business/Ir  Constructi		
Maryland, d 2 should be filed the and Mental Hy, traumatic event,	To Be C	17. Father's Name (First, Middle, Last) Girolamo Barbieri				e (First, Middle, Ma Briganti		
Mich y nd 2 shou alth and A 27 is ma		19a. Informant's Name/Relationship (Type. Print) Delmo Barbieri/Son					City or Town, State, 2	
Saltimore, permit. Pages 1 ar Department of Hes Important: If Item any injury or othe		20a. Method of Disposition  1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 ☑Other (Specify) entombment	Gate of		ce) Cemetery	Sept. 28 2009		Town, State ring, Marylar
Deart permit. Departi Import any inj once.		21. Signature of Juneral Service Licensee  23a. Part 1. Enter the disease, or complications that caused the de	5	00 Univer	rsity Blv	d. W., Si		ng, MD 2090]
Physician /Medical Examiner and the prival-transit the prival-transit	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Acute Myoc Due to (or as a constitution).  Acute Cere Due to (or as a constitution).  Acute Rena C.  Due to (or as a constitution).	equence of):  brovasc  equance on:  1 Failu	ular Acci	unar so			
the death certification by the attending ched for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1	etal death 3 [	☐ Ectopic pregnand ☐ Other (specify)	ру		23d. Date of de Month	llivery Day Year
requires that to seen signed by hould be detact	δ	Part II. Other significant conditions contributing to death but not	resulting in the u	inderlying cause giv	ven in Part I.			o the cause of death?
The law ate has bage 2 s	Completed					24a. Was ar autopsy perform	y prior to ned? death? È⊠No 1 □Ye	utopsy findings available completion of cause of s 2 \( \sum \) No
JII OI Jing Phy After this funeral d	ation: To Be	25. Was case referred to medical examiner?  1  Yes 2 No	28b. Time o	of 28c. Inju	ner: 4 🗆 Nursing H	th (Check only one tome 5 \ Reside 28d. Describe ho	nce 6 ☐ Other (Sp.	ecify)
= 2 ± ± =	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A building, etc. (Sp.	ecny)			City or Town		
To the Hospital within 24 hours a within 24 hours a To the Funeral Completely filled	Medical	29a. Certifier  (Check only one)  1 ★ Certifying Physician: To the best of my 2 ★ Medical Examiner: On the basis of exam and manner stated.  29b. Signature and title of certifier	knowledge, dea nination and/or i	nvestigation, in my 29c. Licen:	opinion, death occu se number	urred at the time, da	ause(s) and manner a ate and place, and du 9d. Date signed (Mor	e to the cause(s)
4		30. Name and address of person who completed cause of death (Samuel A. Semegn, MD 122	Item 23a) (Type		8152	3 S	// //-	904
Sta Registr		Samuel A. Semegn, MD 122  31. Date filed (Month, Day, Year)  SEP 2.5 2000		Orchard	road, Si		Lng, MD 20	<i>5</i> 04

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 09-18-2009 Loretta Irene Belenski 10:45₽M 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Health Bowe If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 1 □ M 2XXF March 7,1941 68 212-38-2125 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1√XYes 2 No Prince George's Maryland Bowie 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number 2709 Keystone Lane 20715 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2XXo Specify: White 3 ☐ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Secretary Computer Entry Private Sector 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unknown unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Earl J. Knowles/Representative 2709 Keystone Lane, Bowie, Maryland lace of Disposition (Name of Date 20c. Location 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burlal 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) 09/23/09 Glen Burnie, Maryland Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a, Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

Physician /Medical Examiner

**Physician** 

Examiner

**Funeral** 

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "noticed Exerciting must be notified at

Department of Health and Mental Hygiene.
Important: If item 27 is marked other typian any injury or other traumatic event, the Macce.

/Medical

10a. State

Director

Funeral

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Completed

Be

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Completed by Physician/Medical Examiner been signed by the attending physician and should be detached for use as the burial-transit s certificate has t lirector, page 2 s within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, Be Medical Certification: To

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

resulting in death)	Due to (or as a consequence of):	
Sequentially list conditions, rany, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a consequence of).	
hat initiated events esulting in death) Last	Due to (or as a consequence of):	
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy  1	23d. Date of delivery  Month Day Year
Part II. Other significant conditions o	orthodaling to document not receiving in the endorsy ing datase gives in a series	d tobacco use contribute to the cause of death? ∃Yes 2 □ No 3 □ Probably 4 □ Onknown
	per	as an topsy findings available topsy from ed? formed? death? 1 □ Ves 2 □ No
25. Was case referred to medical	26. Place of Death (Check only	y one)
examiner? 1-☐ Yes 2 ☐ No	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Home 5   Re	esidence 6 Other (Specify)
27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)  28b. Time of Injury M  28c. Injury at Work? 1 □ Yes 2 □ No	e how injury occurred
3 ☐ Suicide 6 ☐ Could not be determined	286, Place of injury - At nome, farm, street, factory, office   261, Location	(Street and Number or Rural Route Number, own, State)
29a Cartifier 1 Cartifying Ph	by sician: To the best of my knowledge death occurred at the time, date and place, and due to the	he cause(s) and manner as stated

2 - Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

State Registrar and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certificate of Death

4b. City, Town, or Location of Death

Takoma Park Washington Adventist Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 01/29/1954 Social Security Number 7. Age (In yrs. last birthday, **Funeral** Hours Min. Days 1 13 M 2 □ F 578-72-5775 Vrs 55 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show may injury or other traumatic event, the Modical Evanment must be notified at once. 10a. State 10b. County 10c. City, Town or Location Funeral Director DC Washington 10e. Street and Number 10f. Zip Code 1327 Spring Rd. NW 20010 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Eiementary/Secondary (0-12) College (1-4or 5+) Fireman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francis Brown Beatrice Pendleton ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Terrea Brown/ Daughter 1200 Burketon Rd. Hyattsville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) September 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Heritage Cemetery 28, 2009 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stewart Funeral Home, Inc. ature of Funeral Service Lie 4001 Benning Rd. NE Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 51 disease or condition resulting in death) /Medical Due to (or as a censequence of): Examiner henmon Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner al or Attending Physician: The law requires that the death certificate be executed after death.

I Director: After this certificate has been signed by the attending physician and by the burner director, page 2 should be detached for use as the burnal-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 24a. Was an autopsy 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Be

2. Date of Death 3. Time of Death Month 09/21/09 18:20 4c. County of Death Montgomery 9. Birthplace (State or Foreign Country)
DC 10d. Inside City Limits 1 M Yes 2 □ No 10g. Citizen of What Country? United States 14. Race - American Indian, Black, White, etc. Black Specify: 16b. Kind of Business/Industry Government 20783 20c. Location - City or Town, State Waldorf, Maryland Approximate Interval Between Onset and Death 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 2 W NO Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

State Registrar

Medical Certification: To

filled in by

To the Hospital within 24 hours a To the Funeral C

27. Manner of Death

1 Natural

2 Accident

4 Homicide

(Check only one)

3 ☐ Suicide

29a. Certifier

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

1. Decedent's Name (First, Middle, Last)

Keith Anthony Brown

4a. Facility Name (If not institution, give street and number)

**Physician** 

/Medical

Examiner

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TAHMINA

831 University BLVD East 1 Silversity MD University 82. Registrar's Signature

1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

MD

28b. Time of

28c. Injury at Work?

29c. License number

D0060 100

1 ☐ Yes 2 ☐ No

Hospital:

5 Pending

investigation

determined

6 ☐ Could not be

28a. Date of Injury (Month, Day, Year)

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Vear Month 8:05 FM Peter James Brodnax മവാ 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 5. Social Security Number CHARL ENTER 1 Avil Date of Birth (Month, Day, Year) 07/22/1927 7. Age (In yrs. last birthday) If Under Birthplace (State or Foreign Country) Months Hours Min. 1 🔀 M 2 🗆 F Days 82 North Carolina 230-30-2881 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1√TYes 2 No Maryland Prince George Suitland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2606 Fort Drive 20746 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∑XYes 2 ☐ If Yes, Give Year or Dates: 2 □ No 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No **Black** Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **Planner** Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Anderson Brodnax Ruth Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Brodnax/ Son 3603 Oaklawn Rd. Fort Washington, Md. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition September 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Lincoln Memorial 28, 2009 Suitland, Maryland ture of Funeral Service Live 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Rd. NE Washington, DC 20019 23a. Pan 1. Ener the disease, or complications that caused the death. shock, or heart failure. List only one cause on each ligie. Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): NEUTUNI e to (or as a consequence of): 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2 □No 24a. Was an autopsy 1 □Yes 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA

Physician ./Medical **Examiner** 

Department of Health a Important: If Item 27 is any Injury or other trau once.

Pages 1

**Physician** 

Examiner

**Funeral** 

Director

28a-f show

Director

Funeral

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Completed

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Examine

Physician/Medical

Completed

Be

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Certification:

Medical

State Registrar

artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-f shov
Injury or other traumatic event, the Medical Examinar must be notified at

Itimore, Maryland 21215-0036

/Medical

and burial-trar attending physician for use as the buria been signed by the atte should be detached for has

The faw requires that the death certificate be executed

P.O. Box 68760,

Division of Vital Records,

Attending Physician:

To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by

this certificate ours after death.

eral Director; After this certific filled in by the funeral director,

□Yes 2□No 9 Unknown

25. Was case referred to medical examiner?

27. May er of Death ✓ Natural 2 ☐ Accident 5 Pending investigation

3 ☐ Suicide 4 Thomicide

29a. Certifier

6 ☐ Could not be determined

1 🗹 Inpatient 28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work?

1 □Yes 2 □ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred

Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day; 00

30. Name and address 01

and manner stated.

SEP 2 8 2009 31. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** ď℃T.3,2009 2:15A HELEN ENSLOW BLACKBURN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** CHARLES NANJEMOY 9515 IRONSIDES ROAD If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Min. Days MD. 91 Director 214-36-3774 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 ☐ Yes 2X No NANJEMOY Director MD. CHARLES 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 20662 9515 IRONSIDES ROAD Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 □No Specify. Specify: WHITE à 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME HOMEMAKER 12th Department of Health and Mental Hygie Important: If item 27 Is marked other any Injury or other traumatic event, In once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BESSIE ALLEN ERNEST GEORGE ENSLOW ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) NANJEMOY, MD. 20662 PATRICIA WELCH-DAUGHTER 3545 LEVI LANE 20c. Location - City or Town, State Date 20a. Method of Disposition OLD DURHAM CEMETERY 10-7-09 1 N Burial 2 □ Cremation 3 □ Removal from State IRONSIDES, MD. 4 ☐ Donation 5 ☐ Other (Specify) RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 21. Signature of Euneral Service License M00479 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death immediate Cause (Final Physician CONICIPI disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 □Yes 2 No 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐No 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Sesidence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident the 6 ☐ Could not be 3 Suicide . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, attending pl cate has been signed by the page 2 should be detached certificate After this 24 hours after deatl á filled in within 24 ho

To the Fune

completely 1

Pages 1 and 2 should be filed within 72 hours after death with the

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

29b. Signature and title of certifie

FICE

29a. Certifier

(Check only one

and manner stated.

0

29d. Date signed (Month, Day, Year)

Registrar

Medical

15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

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			_ FOF	epartment of Health and N		200	0 921.71.
			riegiotiai	Certificate of Death			
	Physicia	an	1. Decedent's Name (First, Middle, Last)		Date of Deat     Month	Day Yea	
	/Medic		Hence Coleman		09	21 200	
	Examin	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of De	
*			Prince George's Hospital	(day) If Under 1 Year   If Under 24 Hrs.	8. Date of Birth		George's  Sirthplace (State or Foreign
	Funeral		5. Social Security Number 6. Sex 1 図 M 2 口 F 7. Age (In yrs. last birtho	Months Dave Hours Min	(Month, Day	; Year)	Country)
	Director		578-05-5219 95 Yr		9/14/19	914	SC
	land ow		10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits
	Mary -f sh	ţ	MD Prince George's Capital	Heights			1 ☑ Yes 2 ☐ No
	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Mydical Evant activities to infified at	Director	10e. Street and Number	10f. Zip Code	1	l 0g. Citizen of What	Country?
	3a o	교	710 Mentor Ave.	20743		USA	
	ms 2	Funeral		13. Was Decedent of Hispanic Origin? (SI If Yes, specify Cuban, Mexican, Puerto	pecify Yes or No-	14. Race - Ar	merican Indian,
9	or ite		1 ☐ Never Married 2 ☒ Married 1 ☐ Yes 2 ☒ No	1 ☐Yes 2 No Specify:	nicari, etc.)	Black, Wh	nite, etc.
9	ral",	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	TETTES ZENIO Specily.		Specify: B1	Lack
2-0	72 hc	Completed	15. Decedent's Education 16a. D (Specify only highest grade completed) (0	ecedent's Usual Occupation Give kind of work done during most of work	kina	16b. Kind of Busines	ss/Industry
21	within ene.	npl	Elementary/Secondary (0-12) College (1-4or 5+)	Give kind of work done during most of work fe. DO NOT use retired)			
7	ed w ygier ygier her th			rtified Plumber	(F)		Government
בַ	be fill d oth even	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	ie (First, Middle, i	Maiden Surname)	
Z	es 1 and 2 should be filed within of Health and Mental Hygiene. If them 27 is marked other thar in other traumatic event, I and	은	Charley Coleman	Eva Sta			
<u>Ja</u>	2 sh h and is m			failing Address (Street and Number or Ru		•	
e oĵ	and Health			O Mentor Ave. Capit		hts, MD 20	
0	Pages 1 nent of h int: If ite iry or ot			isposition (Name of crematory or other place)		200. Location - City	or rown, state
Ē	t. Pa tmer tant:				, ,	Landover	
Baltimore, Maryland 21215-0036	permit. Page Department of Important: If any Injury or once.		21. Signature of Puneral Service Licensee	22. Name and Address of Facility Ma			Home
	⊕ □ = @ O		y. P. Marinace	4217 9th St NW Was			A d
			23a. Part1. Ther the disease, or complications that caused the death. Do no shock, or heart failure. List only one cause on each line.	t enter the mode of dying, such as cardiac	or respiratory ari	rest,	Approximate Interval Between Onset and Death
. I	Physician		Immediate Cause (Final disease or conditiona Fatal Card	iac Arrhythmia			
	/Medical Examiner		resulting in death)  Due to (or as a consequence of)				
	Examine	L	Sequentially list conditions, b. Hypertens				
	ed sit	ine	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or Injury  Cause (Disease or Injury  Cancer of				
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/89	leath certificate attending physi I for use as the b		d				
	death certifica e attending ph d for use as th	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of	delivery
ROX	atter for u	ciar	in the past 12 months?	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		Month	Day Year
o.	0 0	ysic	1   Yes 2   No 9   Unknown	J E Other (specify)			
J.	requires that the been signed by th		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.	23e. Did to	bacco use contribute	e to the cause of death?
Vital Hecords,	uires n sigr ld be	d by			1 □ Y	es 2□No 3□	Probably 4X Unknown
<del>ဂ</del> ္ဂ	v req	Completed			24a. Was a	an 24h Were	autopsy findings available
Ě	The law ate has b bage 2 sh	ם			autop: perfor	sy prior med? death	to completion of cause of
g	n; Ti ficate n, pa		OF Was seen referred to modified		1 □Yes		es 2□No
5	I or Attending Physician: The law Director: After this certificate has b In by the funeral director, page 2 si	Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  Hospital: 1 ☐ Inpatient 2 ☒ ER/Outo	Othor	th (Check only or		
0	Phy rrthis	ertification: To				lence 6 Other (S	pecity)
DIVISION	ding th. Afte fune	흲	27. Manner of Death  1  Natural 5 □ Pending 2 □ Accident investigation  28a. Date of Injury (Month, Day, Year) Injury (Month, Day, Year)	ne of 28c. Injury at Work?  M 1 □ Yes 2 □ No		,,	
<u>.</u>	Atter deal	ica	3 ☐ Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm	, street, factory, office	28f. Location (S	Street and Number or	Rural Route Number,
S	after Dire	erti	4 Homicide determined building, etc. (Specify)		City or Tow	n, State)	
	spita nours nera y fille	a C	29a. Certifier 1⊠ Certifying Physician: To the best of my knowledge,				
	To the Hospital or Attendi  within 24 hours after death.  To the Funeral Director: A completely filled in by the fi	ledical	(Check only 2 Medical Examiner: On the basis of examination and/one) and manner stated.	or investigation, in my opinion, death occu	irred at the time,	date and place, and	due to the cause(s)
	To th To th comp	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Me	onth, Day, Year)
	7		) min	722305		9.22.09	
	1		30. Name and address of person who completed cause of death (Item 23a) (Ti				
			Massoud Nemati MD, 3001 Hospital	Dr. Cheverly MD 20	785		
	Sta	ite	31. Date filed (Month, Day, Year) 32 Registrar's Signature				
	Registr	ar	SEP 25 2009 Server B. A.	our -			

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Physician	
/Medical	
Examiner	

**Funeral** 

Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a, State 10b. County Severna Park MD Anne Arundel Director 10e. Street and Number 10f. Zip Code 21146 500 Saint Martins Lane by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: 3 Widowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 'Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Construction Worker 11 17. Father's Name (First, Middle, Last) Be Mary Dominic Civitarese 19a. Informant's Name/Relationship (Type. Print) Mary Ann Roberts / Sister 20b. Place of Disposition /Name of 20a. Method of Disposition Date 1 Bunal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glent Haven Methor 121 Sept. 23, 2009 Park 21 Signature of Funeral Service Licensee Barranco & Sons 23a. Part . Enter the disease, of shock, or heart failure. List r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner use as the burial-trar Due to (or as a consequence of): P.O. Box 68760. nding physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, ģ Completed 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 21 NO 1 TYes 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 A Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No r death. after death 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide 29a, Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier D31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9005 KILBRIDE RD, BALTIMORE, MID 21236 WALLACE MIS 32. Registrar's Signature 31. Date filed (M State Registrar

2. Date of Death 3. Time of Death Month P. Civitarese 7:58 p M James 2009 Sept 18, 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Severna Park Center Genesis Anne Arundel Severna Park 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months 1 X M 2 □ F 213-28-4136 March 25,1926 Pennsylvania 10d. Inside City Limits 1 ☐ Yes 2 X No 10g. Citizen of What Country? USA 14. Race - American Indian, White 16b. Kind of Business/Industry Construction 18. Mother's Name (First, Middle, Maiden Surname) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Saint Martins Lane Severna Park, MD 21146 20c. Location - City or Town, State Glen Burnie, MD Barrancod Scolly, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death YEARS ATHEROSCIEROTIC CARDIOVASCULAR DISEASE 23d. Date of delivery Month 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Descrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) SEPTEMBER 22 2009

Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician:

State Registrar

31. Date filed (Month, Day, Ye SEP 2 8 2009

and manner stated.

(Check only

of certifier

29b. Signature a

30. Name and

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

D16364

29d. Date signed (Month, Day, Year)

09-23-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend #20b Per FH & Tificale 18/ Beath 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 11:32aM Leo Martin Dehnel September 17, 2009 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 X M 2 □ F Yrs Texas July 26, 1924 85 Director 466-16-9940 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits show 10a. State d other than "natural", or items 23a or 28a-f sho 1 ☐Yes 2 No Director Hollywood Maryland Saint Marys 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20636 U.S.A. 26460 Peninsular Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 MaYes 2 □ No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Saltimore, Maryland 21215-0036 1 ☐Yes 2 🛣 No Specify Specify: þ Caucasian 3 Widowed 4 Divorced WWIT Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry alth and Mental Hygiene, 27 is marked other than "I r traumatic event, the Mon should be filed within Elementary/Secondary (0-12) College (1-4or 5+) 4 Artist U.S. Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Paul E. Dehnel Ava Lee Rutledge ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) item 27 is other tra 5535 Old Fort Jupiter Road, Jupiter, Florida 33458 Margarete Crook - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place, ulca Date 20c. Location - City or Town, State 20a. Method of Disposition i fit Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. :10/16/2009 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Crematory Brentwood, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Approximate Interval Between Onset and Death 23a. Pirt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shift, in heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Renal Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Colitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 5 ☐ Other (specify) ☐Yes 2☐No been signed by the should be detached 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Prostate Enlargement Completed 24a. Was an page 2 s autopsy perform this certificate 1 □Yes 2 🗷 No director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

Box 68760, P.O. of Vital Records, al or Attending P after death. I Director: After i d in by the funera Division filled in by To the Hospital or within 24 hours at To the Funeral D

1 Tes 2 No 3 Probably 4 I Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Decrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one and manner stated

29c. License number

D56691

29d. Date signed (Month, Day, Year)

September 17, 2009

State Registra

Medical

29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hano

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #17 Per History Mary and Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month September 22, Year 2009 **Physician** Farrell T. . 9:20 al /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 302 E. Wainscot Drive Frederick New Market 8. Date of Birth (Month, Day, Aug. 7, If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2**ॉ**F Months Days Hours New York 076-14-9851 Director 89 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits show Examine count by notified at 1 ☐ Yes 2 ☐ No Director 28a-f Maryland Frederick New Market 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö items 23a 302 E. Wainscot Drive 21774 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🔏 No
If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 6 1 ☐Yes 2 X No Specify: Specify: White <u>Ş</u> 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Montgomery County Health Room Technician Health Department 17. Father's Name (First, Middle, Last) .. Pages 1 and 2 should be file tment of Health and Mental H tant: If Item 27 is marked ott Be 18. Mother's Name (First, Middle, Maiden Surname) Lally William Francis Farrell Veronica Radford ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John F. Farrell/Son 302 E. Wainscot Drive, New Market, MD 21774 Baltimore. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If It any Injury or c 2 t Burial 2 ☐ Cremation 3 ☐ Removal from State Nov. Arlington Nat'l Cemetery 4 Donation 5 Dother (Specify) 2009 Arlington, Virginia 21. Signature of Furjeral Service Licensee 22 Name and Address of Facility
Francis J. Collins Funeral Home Inc. lian 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Colon Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (ursease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Year Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown After this certificate has been signed funeral director, page 2 should be def Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Tes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 1 ☐ Yes 2 ☐ No 1 ∐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated. 29b. Signature and After of certifier 29c. License number 29d. Date signed (Month, Day, Year) mo 9-23-09 D0058726

Registrar
DHMH 17 Rev 1/2001

State

3000-D Ventrie Court, Myersville, MD 21773

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Yvette Marie Lopez-Warren, MD

25 2009

31. Date filed (Month, Day, Year)

		1 - State of Maryland / Dep	partment of Health and ertificate of Death			32480
Physici	ian/	1. Decedent's Name (First, Middle, Last)	itincate of Death	2. Date of Death		3. Time of Death
Med	ical		1		r 23, 2009	10:50 p <sup>M</sup>
Exami	ner	4a. Facility Name (if not institution, give street and number) Friends Nursing Home	4b. City, Town, or Location of Death Sandy Spring	1	4c. County of Death	
Funera		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 010−20−9495 1 □ M 2 🖾 F 8.6	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.		9. Birth	place (State or Foreign
Directo	r	010-20-9495	Worth's Days Hours Will.	Sept. 20	, 1923 Mas	sachusetts
land show dat	ρ	10a. State 10b. County 10c. City, Town or Li	ocation			10d. Inside City Limits
Mary 28a-f otifie	irec		ington			1 🗌 Yes 2 🎦 No
ith the	Funeral Director	10e. Street and Number 11002 Waycross Way	10f. Zip Code 20895	10	g. Citizen of What Cou	ntry?
eath w tems ?	l e	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (Sr	pecify Yes or No-	USA 14. Race - Ameri	can Indian
36 after d ", or i		1 ☐ Never Married 2 ☐ Married  Armed Forces? 1 ☐ Yes 2 ☐ You If Yes, Give	If Yes, specify Cuban, Mexican, Puerto  1 Yes 2 No Specify:	o Rican, etc.)	Black, White,	etc.
nours a	Completed by	3 E Vildowed 4 Divorced Year or Dates.	edent's Usual Occupation		Specify: Wh:	
215 in 72 t e. nan "n	l m	(Specify only highest grade completed) (Give	kind of work done during most of work DO NOT use retired)	king	6b. Kind of Business Ir	dustry
d with dygien ther ther ther ther ther	BeC		Homemaker		Own Home	
Maryland 21215-0036 2 should be filed within 72 hours after th and Mental Hygiene. 27 is marked other than "natural", or traumatic event, the Medical Exam	10 B	17. Father's Name (First, Middle, Last)  John Taylor	18. Mother's Nan Eva Be	ne <i>(First, Middle, Ma.</i> elisle	iden Surname)	
ary hould and M is mar		19a. Informant's Name/Relationship (Type, Print) 19b. Mail	ing Address (Street and Number or Rui	ral Route Number, C	ity or Town, State, Zip	Code)
		Thomas B. Fanning/Son 110	002 Waycross Way,	Kensingto	on, MD 2089	95
<b>Baltimore,</b> oermit. Page 1 and Department of Hea Important: If item any injury or other once.		20a. Method of Disposition   20b. Place of Disposements   1   S Burial 2   Cremation 3   Removal from State   Gate of Cate o		·. 28. l	Oc. Location - City or To	· ·
Baltimor permit. Page 1: Department of I Important: If its any injury or of once.		Cemeter Cemeter	v Name and Address of Facilities		Silver Spri	.ng, MD
		Moun Gener	000 University Blv	d. W., Si	lver Sprin	g, MD 20901
	l	23a. Part . Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	er the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between
Physician/ Medical		disease or condition resulting in death)  Congestive Heart  Due to (or as a consequence of):	Failure			Onset and Death
Examiner		Dementia				
d sit	nine	Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or linjury				
ecute and	Exar	Cause (Disease or injury that initiated events c. Due to (or as a consequence of):				
ate be executed only sician and the burial-transit	dical Examiner	d				
oo/o	Мед	IF FEMALE:				
death celle attendied for use	cian/	23b. Was decedent pregnant in the past 12 months? 1 Use Birth 2 Fetal death 3 1 Ves 24 No. 4 Pregnant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of deliver	ery Day Year
y F.O. box 6879 ss that the death certifica igned by the attending p be detached for use as t	Physician/Me	1  Yes 2X No 4  Pregnant at time of death 5 L g Unknown	Uniter (specify)		World	Day real
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e Cords, e law requires has been sig	eted			1 \( \text{Yes}	2 No 3 Prol	oably 4 🔁 Unknown
e law r e has b ge 2 sl	Completed			24a. Was an autopsy	prior to co	osy findings available mpletion of cause of
an: The tifficate for, pag	Be Co	25. Was case referred to medical	26. Place of Death (Chec	performe 1  Yes 2	No 1 Yes	2 🗆 No
VIC hysicia nis cer I direct	To B	examiner? 1	CIL		e 6 Other (Specify	,
II OI VILAI NEC ding Physician: The la h. After this certificate ha funeral director, page	ate:	27. Manner of Death 1 → Natural 5 → Pending 28a. Date of injury (Month, Day, Year) 28b. Time of injury	28c. Injury at work?	28d. Describe how i		
Attendir r death. ector: Af	Certificate:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury. At home, farm, str	M 1 ☐ Yes 2 ☐ No	28f Location (Street	at and Number or Rural	Pouto Number
talor rs afte al Dire		4 Homicide determined building, etc. (Specify)	1	City or Town, S		noute Nutriber,
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or inves	tigation, in my opinion, death occurred a	t the time date and n	lace and due to the car	sea(e) and mannor stated
To the within to the comple	Σ	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, a 29b. Signature and title of certifier	death occurred at the time, date and place 29c. License number	ce, and due to the cau	use(s) and manner as sta . Date signed (Month, L	ated.
3		M Sember CA	20520	7 2	2 toulian	24.2009
		30. Name and address of person who completed cause of death (Item 23a) (Type, F John G. Lodmell, MD 2901 Olney-Sai	Print) ndy Spring Road (	Olnev. MD	20832	- 1) 1
Sta	te.		The state of the s	- Incy, FID		
Registr		SEP 25 2009 Common S. Again	Kar.			

		Plea  1 - For State Registrar	se Type or P State of		nd / Depa		Health and I	•	-	ible.	32481
Physici: /Medic		1. Decedent's Name (First, Middle						2. Date of De Month OCTOBER	Day	Year	3. Time of Death 5:40 P M
Examin	er	4a. Facility Name (If not institution THE NATIONAL  5. Social Security Number	LUTHERAN H	OME	s. last birthday)		PROCKVILLE  If Under 24 Hrs.		MON	TGOME	
Funeral Director		236-50-0939 Usual Residence of Decedent	1 M 2 F	75	Yrs.	Months Days		9/13/1	934	WEST	VIRGINIA
show	ō	10a. State 10b. County	KELEY	10c. C	ity, Town or Lo	cation TINSBURG					10d. Inside City Limits 1 ☐ Yes 2 🕅 No
h the M or 28a-1	<b>Funeral Director</b>	WV BER  10e. Street and Number	NELET			10f. Zip Code			10g. Citizen of	What Cou	
ath wil	ral	31 MANOR DRIV				2540			US		
s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Memlard Hygiene. The file Trans 23a or 28a-f show other traumatic event, it at the file of the restrict must be redified at	þ	11. Marital Status  1 □ Never Married 2 □ Marri 3 ☑ Widowed 4 □ Divorced	12. Was Deceded Armed Force 1 Tyes 2 If Yes, Give Year or Date	≱s? <b>X</b> ∏No		Was Decedent of I fYes, specify Cub I□Yes 2□\No	Hispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No o Rican, etc.)	Spec	ack, White,	ican Indian, etc. WHITE
72 ho	eted	15. Decedent (Specify only highes	's Education it grade completed)		16a. Deced	dent's Usual Occu kind of work done	pation during most of worl	king	16b. Kind of I		
d within giene.	Completed	Elementary/Secondary (0-12)	College (1-4	or 5+)	life. L	OO NOT use retire CLEF			COUNTY	COUR	RTHOUSE
should be filed and Mental Hy, s marked other umatic event,	To Be C	17. Father's Name (First, Middle, I	*				18. Mother's Nam OLA A		, Maiden Surna	ime)	
and 2 sho lealth and m 27 is m		19a. Informant's Name/Relationsh DAVID LYON/NE					TRAIL, AU				p Code)
pormit. Pages 1 and 2 s Department of Health a Important; If item 27 is any injury or other trau		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp			Place of Dispo- cemetery, cren SEDALE CE	sition (Name of natory or other pla METERY	сө) ОСТОЕ 200	ER 7,	20c. Location	-	own, State URG,WV
permit. Departm Importa any inju		21. Signature of Funeral Service I		1 1 1 1		. Name and Addr		OWN FUNERA	AL HOME,	PO BOX	
Physician /Médical Examiner	Examiner	23a. Part 1. Enter the disease, or shock, or heart failure. List of immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter the death of the cause (Disease or injury that initiated events resulting in death) Last	a. A Due to (or b. Due to (or c	h line.	quence of):	er the mode of dyi	1.00				Approximate Interval Between Onset and Death
the Hospital or Attending Physician: The law requires that the death certificate be ex hin 24 hours after death. the Puneral Director: After this certificate has been signed by the attending physician ampletely filled in by the funeral director, page 2 should be detached for use as the burial.	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	d	me of pregr th 2 □ Fet nt at time of	nancy al death 3 death 5	Ectopic pregnani Other <i>(specify)</i>				ate of deliv	very Day Year
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To the Hospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page:	ation: To	27. Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Date of (Month,		28b. Time of Injury	28c. Inju Woo		ome 5 ☐ Resi 28d. Describe	how injury occu		rty)
tal or Att	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	28e. Place of	Injury - At h etc. (Spec	nome, farm, stre	eet, factory, office		28f. Location ( City or To	Street and Num wn, State)	ber or Run	al Route Number,
ne Hospit n 24 hour ne Funer	edical	29a. Certifier 1 Certifying (Check only one) 1 Medical E	g Physician: To the be examiner: On the basi and manner	s of examin	owledge, death ation and/or inv	occurred at the t restigation, in my	ime, date and place opinion, death occu	, and due to the rred at the time,	cause(s) and r date and place	nanner as , and due t	stated. to the cause(s)
To the within com	Ž	29b. Signature and title of certifier	ans	,		29c. Licens	se number	(	29d. Date sign		Day, Year)
81		30. Name and address of person v	vho completed cause of	2 .		Print)	ROCKUILL				
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Registra		OCT 09	2009	··· ,	1. pa	Mal					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 20 ay Shanti Parkash Gulati sept. 2009 3:30A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Shady Grove Adventist Hospital Rockville Montgomery 8. Date of Birth (Month, Day, Year)
Sept. 21, 1920 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Months Days Hours Min. 88 579-70-5107 Director India Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Medical Examinar must be notified at MD Derwood Montgomery Director 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 9 Tarpley Ct. 20855 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. 1 ☐ Never Married 2 ☐ Married 1 ∐Yes 2 If Yes, Give Baltimore, Maryland 21215-0036 1 □ Yes 2 X No Specify þ Specify: Indian 3 XWidowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Washington Hospital Center Elementary/Secondary (0-12) College (1-4or 5+) Research Administrator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ram Lal Gulati B. W. Gulati ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Vinod Gulati/Son 9 Tarpley Ct., Derwood, MD 20855 Date 23, 20b. Place of Disposition (Name of cemetery crematory or other place)
Fairfax Memorial 20a. Method of Disposition 20c. Location - City or Town, State Sept. 1 ☐ Burial 2 【\*\*Cremation 3 ☐ Removal from State Fairfax, 4 □ Donation 5 □ Other (Specify) 2009 Funeral Home 22. Name and Address of Facility Fairfax Memorial Funeral Home, 9902 Braddock Rd., Fairfax, VA22032 21. Signature of Funeral Service Licensee CC0451 Gernadette 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Toxic Megacolon disease or condition resulting in death) /Medical Examiner Clostridium difficile colitis Sequentially list conditions, if any, reading to humadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-trar Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Hlnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy performed? certificate 2 No 1 ∐Yes 2 🔀 No 1 🗌 Yes Hospital or Attending Physician: '24 hours after death. Funeral Director: After this certifica ttely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2X No Certification: To 1 Inpatient 2 I ER/Outpatient 3 I DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending Injury investigation 1 □Yes 2 □ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C completely filled in the Funeral C completely filled in the second complete 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier (Check only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) D42518 September 20, 2009 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gul Chablani 11119 Rockville Pike, #401, Rockville, MD 20852 31. Date filed (Month, Day, Year) Registrar's Signature State 25 SEP 2009 Registrar

2x 23/10k

			For	State of I	Maryland / Dep			l Hygiene	0000	v
			1 - State Registrar		Ce	rtificate of De	eath	Reg. No	. 2011	3240
	Dhyalai		1. Decedent's Name (First, Midd	lle, Last)				of Death th _ Day	v Year	3. Time of Death
	Physici /Medio		Margaret	Rachel	Gibson		Sep	t. 25	2009	17 18 1
	Examin		4a. Facility Name (If not institution Memorial Ho		er)	4b. City, Town, or Lo Easton	cation of Death		County of Death	
	Funeral Director		5. Social Security Number 222182672	6. Sex 7.	Age (In yrs. last birthday, Yrs.		Under 24 Hrs. 8. Date Hours Min. (Mor Aug	of Birth ofth, Day, Year) 5 , 1 9	9. Birthy Cour	place (State or Foreigntry) DE
pu	3		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town or Lo	neation				Od, Inside City Limit
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ith the N	or 28a-l	Director	Maryland Que	en Anne's	Queen	Anne 10f. Zip Code		10g. Cit	izen of What Cour	ntry?
ath w	23a		13623 First S	treet		21657				s of Ameri
er de	tems	Funeral	11. Marital Status	12. Was Decede Armed Force		Was Decedent of Hispa If Yes, specify Cuban, I	anic Origin? (Specify Yes Mexican, Puerto Rican, e	or No-	<ol> <li>Race - Americ Black, White,</li> </ol>	
5-0036 72 hours after death with the Maryland	natural", or items 23a or 28a-f show digal Examinaticust be notthed at	þ	1 Never Married 2X Mar 3 Widowed 4 Divorced	If Yes, Give	es:		Specify:			casian
O N	E 3	Completed	15. Deceder (Specify only highe	nt's Education est grade completed)	16a. Dece (Give	edent's Usual Occupation of kind of work done duri OO NOT use retired)	on ing most of working	16b. K	ind of Business/In	dustry
within	than h	ם	Elementary/Secondary (0-12)	College (1-4d	or 5+)					
filed v		ပိ	12 HS Grad 17. Father's Name (First, Middle,	(ast)		Homemake:	<u>r.</u> 3. Mother's Name <i>(First, i</i>	Middle Maiden	Home Surname)	
and be	ental Hyged others event,	Be			Tomo -				,	
Jog N	th and Mer 7 Is marke traumatic	ပ္	Melvin  19a. Informant's Name/Relations		James	na Address (Street and	Margaret Number or Rural Route		-	n Code)
<b>S</b> 2 s	Ith ar 27 Is trau			, , , , ,	- 4	•				·
ຄຸ <sup>+</sup>	f Healt Item 2 other		John L. Gibson 20a. Method of Disposition	Husb	20b. Place of Disp	osition (Name of	Queen Anne,	_Mary La	ocation - City or To	own, State
mor Pages	್ಲಿ = 5		1 Burial 2 Cremation	3 Removal from Sta	ate   "	matory`or other place)	0 /00 /000		- 1	
<b>SAITIMO</b> permit. Pages	E 25 -		4 Donation 5 □Other (5	A	Capitol	2. Name and Address of	ry: 9/28/200 <sup>of Facility</sup> Moore F	19   DOVE	er, Delav	ware
De la	Depa Impo any Ir once		Houle	WW/n			cond Street			
			23a. Part1. Enter the disease, o	or complications that cau	sed the death. Do not en				ii, iarji	Approximate
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	ysician Medical		disease or condition resulting in death)	a. Dung (or	as a consequence of):	rigar	Chon			1 neuv
E	caminer			At	horase 14	VOSIS				15 VOS
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or	as a consequence of):	103/-				7.0
J, executed	d ansit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	S. Hui	ser lipid	emia				20115
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50/00 ficate be	physician and the burial-transit	edical		d						
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O. BOX ne death cer	within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending i completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE:  23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 No 9 □ Unknown		th 2 Fetal death 3 nt at time of death 5	☐ Ectopic pregnancy ☐ Other ( <i>specify</i> )		_	23d. Date of deliv Month	rery Day Year
r ta	ed by detac		Part IJ. Other significant conditi	ions contributing to deat	h but not resulting in the u	ınderiying cause giyen i	in Part I. 236	e. Did tobacco	use contribute to t	the cause of death?
ires t	signe d be o	þ	AAA.GER	21) . Kid	1811 0/1586	ce strice	7 '			babiy 4□ Unknow
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e law	has t e 2 s	Completed	Kenal HYTER	y Steno	515; /ty	Der Tensi	on; 248	a. Was an autopsy	prior to co	opsy findings availab ompletion of cause of
L K	cate pag	Š	Atrial tib	cillatio	2		1 🗆	performed? Yes 2	death? 1 ☐ Yes	2 □ No
VILAI ician:	sertifi actor,	Be	25. Was case referred to medica examiner?				6. Place of Death (Check	only one)		
JI J	this o	ျ	1 Yes 2 No		patient 2 ER/Outpatie		4 ☐ Nursing Home 5			ify)
SION OF	After uner	i.i.	27. Manner of Death 1 Matural 5 ☐ Pendi	ing .	Injury 28b. Time of Injury	Work?		scribe how inju	ry occurred	
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or A	after i <b>Direc</b> in by	ertification:		mined 28e. Place of building,	Injury - At home, farm, st , etc. <i>(Specify)</i>	reet, factory, office	281. Loc City	ation (Street ai or Town, State	nd Number or Rur e)	ai Houte Number,
L	hours a	O			est of my knowledge, dea					
e Ho	n 24 he Fu pletel	edical	(Check only 2 Medical one)	el Examiner: On the basi and manner	is of examination and/or i r stated.	nvestigation, in my opin	ion, death occurred at th	e time, date an	d place, and due t	to the cause(s)
To th	withi To tl comj	ME	29b. Signature and title of certific	er /	N	29c. License n	umber	29d. Da	ate signed (Month,	Day, Year)

29c. License number 046820 29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 21601

State Registrar



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month June Marie Haupt Detober AM 238 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Washington County Hospital Hagerstown Washington Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 217-30-5773 1 🗆 M 2 🖾 F 75 Months Days Hours Min (Month, Day, Year) 10 28 ,1934 Director Maruland Usual Residence of Decedent show 10a. State ral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 10d. Inside City Limits Washington Boonsboro Md. 1 Yes 2 X No 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21713 21523 National Pike U.S.A12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. Completed by Yes 2 No 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: "natural", White 3 X Widowed 4 Divorced Specify: Year or Dates. of Health and Mental Hygiene. Item 27 is marked other than "natur other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Mildred Mulligan 2 John Powell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14340 Greencastle Pike Hagerstown, Md. Greg Haupt (Son) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 and Department of Hamportant: If ite any injury or ot Oct. Date 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Smithsburg, Md. Smithsburg Crematory 2009 Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. *MO1414* J.L. Davis Funeral Home Smithsburg,Md Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) METASTATIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-tran attending physician and that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) 4 Pregnant a
9 Unknown Pregnant at time of death Month Day Year r signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 ☑No 3 ☐ Probably 4 ☐ Unknown Completed 1 Tyes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has t autopsy performed' After this certificate 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical examiner?

1 Yes 2 No director, Be 26. Place of Death (Check only one) Hospital: Other: 유 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 A Natural 5 Pending Accident Suicide 1 Tyes Investigation 2 🗌 No 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide determined edical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifie 29c. License number MO

Registrar

State

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31. Date filed (Month, Day,

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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istrar's Signatur

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Physicia /Medic		1. Decedent's Name (First, N	the contract of	E.	HA	RR.	761	4 N		2. Date of D			3. Time of Death 10:00A M	
Examin		4a. Facility Name (If not instituted CHARLES CO				EHAB.	4t	c. City, Town, o	or Location of Deat PLATA	h		4c. County of Death CHARLES		
Funeral Director		5. Social Security Number 579-10-6683	6. 5	Sex I□M <b>X</b> □F	7. Age (	'In yrs. last bi		Under 1 Year lonths Days		8. Date of B Month, D	1920	9. Birth	place (State or Foreign ntry)	
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vithin 72 ho sne. han "natul Medical	mpletec	15. Dece (Specify only h Elementary/Secondary (0-			(1-4or 5+)		(Give kind life. DO	NOT use retire	during most of wo	rking		nd of Business/Ir I HOME	ndustry	
permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene Department of Health and Mental Hygiene I filem 27 is marked other than "natural", any injury or other traumatic event, I'm Medical Exagnoce.	To Be Co	10th 17. Father's Name (First, Mic JOHN W.OL					ROMI	EMAKER	18. Mother's Nat		e, Maiden	Sumame)		
tnd 2 shou atth and N 27 is mar er traumat		19a. Informant's Name/Rela					0		t and Number or R		-		D.20693	
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The ate pag	Completed									24a. Wa aut per 1 □Yes	opsy formed?	24b. Were aul prior to c death?	copsy findings available ompletion of cause of	
/sician: The s certificate director, pag	Be	25. Was case referred to me examiner? 1 ☐ Yes 2 No	dical	Hospital:	Innatient	2 🗆 ER/0	Outpatient	3□ DOA Ot	26. Place of De	ath (Check only	one)	6 ☐ Other (Spec	ifu)	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	ation: To	27. Manner of Death Natural 5 □ Pe	nding estigatio	28a. Dat (Mo	e of Injury onth, Day,		. Time of Injury	28c. Inju		28d. Describe			any)	
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To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical			miner: On the		xamination a			time, date and place opinion, death occ					
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8 v		30. Name and address of pe	rson who	completed ca	use of dea	th (Item 23a	ı) (Type, Prir	ALD	hAmp elf	ND.	20	EHAL 60 >	ID, MD	
Sta Registr		31. Date filed (Month; Day;	(ear)	19	Registrar	s Signature	box		,					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		1 - State of Maryla State of Maryla	-	artment of Health an rtificate of Death	, ,	ene g. No. 2069	32486
Physic /Medi		1. Decedent's Name (First, Middle, Last)  Lawrence E. Johnson			2. Date of Death Month Sept.	Day Year 2009	3. Time of Death 10:20 A M
Exami		4a. Facility Name (If not institution, give street and number) 4154 Silver Park Terrace		4b. City, Town, or Location of E		4c. County of Death Prince G	
Funeral Director			rs. last birthday) 66 Yrs.	If Under 1 Year If Under 24	Hrs. 8. Date of Birth (Month, Day, Oct. 31.	Year) 9. Birthp	place (State or Foreign
show	'n		City, Town or Lo				0d. Inside City Limits 1 XYes 2 □ No
with the Mi	Director	MD PG  10e. Street and Number		10f. Zip Code	10	g. Citizen of What Cour	_
5-0036 72 hours after death with the Maryland natural", or items 23a or 28a-f show after Examiner must be rediffed at	by Funeral	4154 Silver Park Terrace  11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in Armed Forces?  1 Yes 2 Mo If Yes, Give Year or Dates:	U.S. 13. \	20746  Was Decedent of Hispanic Origin f Yes, specify Cuban, Mexican, P  □ Yes 2 ☑ No Specify:	? (Specify Yes or No-	14. Race - Americ Black, White,	can Indian, etc.
	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)	(Give iife. L	dent's Usual Occupation kind of work done during most of DO NOT use retired) Engineer	working 1	6b. Kind of Business/In	
re, Maryland 212 s 1 and 2 should be filed within f Health and Mental Hygiene, item 27 is marked other than other traumatic event, the	To Be Co	17. Father's Name (First, Middle, Last)  Junior Johnson			Name (First, Middle, M.	aiden Surname)	
ore, Mary ss 1 and 2 shou of Health and M i item 27 is man	_	19a. Informant's Name/Relationship (Type. Print)	4154	g Address (Street and Number o	r Rural Route Number,		Code)
altimore, mit. Pages 1 an partment of Hea portant: If item 2 y Injury or other ce.		20a. Method of Disposition 20th		land, Md. 20 sition (Name of natory or other place) rematory 9/		oc. Location - City or To	
Baltimo		21. I gnaure of Funeral Service Licensee	/ \	Name and Address of Facility 910 Silver H	ill Rd.,	Suitland,	Md.20746
Physician /Medical Examiner	er	23a Part 1. Enter the disease, or complications that caused the definock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate	e fuence of):	er the mode of dying, such as car	diac or respiratory arres	st,	Approximate Interval Between Onset and Death
68760, tificate be executed g physician and as the burial-transit	edical Examiner	Sequentially list conditions, if any, leading to immediate educed. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a cons d. d.					
death certi	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnant in the past 12 months? 4 □ Pregnant at time of the pregnant in the past 12 months? 9 □ Unknown	etal death 3	Ectopic pregnancy Other (specify)	-	23d. Date of delive Month	ery Day Year
ecords, P.O. law requires that the as been signed by the 2 should be detached.	þ	Part II. Other significant conditions contributing to death but not r	esulting in the un	derlying cause given in Part I.		cco use contribute to th	
The The atter had bage	Completed				24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of
of Vital Physician: rthis certifica	Be C	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2	T 50/0 4-4-4	Other	Death (Check only one)		
Vision of Attending Physic death. ector: After this by the funeral din	ation: To	27. Mapner of Death  1 Natural 5 Pending (Month, Day, Year)  2 Accident investigation	28b. Time of	28c. Injury at Work?  M 1 Yes 2 No	28d. Describe how	ce 6 ☐ Other (Specify injury occurred	ý)
Division tal or Attending rs after death. al Director: Afte ed in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spe	home, farm, stre cify)	et, factory, office	28f. Location (Stre City or Town,	et and Number or Rura State)	l Route Number,
Division o To the Hospital or Attending Ph within 24 hours after death to the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one)  1	nowledge, death nation and/or inv	estigation, in my opinion, death c	lace, and due to the car occurred at the time, dat	use(s) and manner as s e and place, and due to	tated. the cause(s)
To 1 To t com	Σ	29b. Signature and title of certifier		29c. License number	290	Date signed (Month, 1	Day, Year)
R4		30. Name and address of lerson who completed cause of death (II	9 0 00	Print) Comy	Smuss	upn	0K46
Sta Registr		31. Date filed (Month, Day, Year) \$2. Registrar's Sig SEP 2 8 2009	backs		0		~ 5

For State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:40 am George A. Kontostergios September 24 2009 /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Arcola Nursing Home Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠** M 2□ F Director 579-70-2477 68 February 20,1941 Greece Usual Residence of Decedent 10a. State 10h. County 10c. City. Town or Location show 10d. Inside City Limits ir than "natural", or items 23a or 28a-f show Director 1 ☐ Yes 2 X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2718 Arcola Avenue Funeral 20902 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □Yes 2 🗷 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No \$ Specify: 3 Widowed 4 Divorced Specify Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) ss 1 and 2 should be filed within of Health and Mental Hygiene, item 27 is marked other than "cother traumatic event, the Mexical and the straumatic event, the Mexical and the strain and the Elementary/Secondary (0-12) College (1-4or 5+) 4 Procurement Officer Federal Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဥ Aristoteles A. Kontostergios Kalliope Papaioanou 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important; If item 27 any injury or other to Angie G. Kontostergios - Wife 2718 Arcola Avenue, Silver Spring, Maryland 20902 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Pages nent of I 1 ■ Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Gate of Heaven Cemetery 09/29/2009 Silver Spring, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 55 Mach Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Levy Body Dementia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical the IF FEMALE: 23c. If <u>ye</u>s, outcome of <u>pregnancy</u> 23b. Was decedent pregnant 23d Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 5 ☐ Other (specify) ned by the a 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? has 24a. Was an autopsy 1 □ Yes 2 🗷 No 2 🗆 No 1 Tyes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 2 Accident investigation 1 ☐Yes 2 ☐ No 24 hours after death e Funeral Director: 3 ☐ Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) within 2 To the I To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D52261 September 24, 2009 CLAN 30. Name and address of person who completed cause of death (Item 23a) (Type/Print) 1517 Hugo Circle, Silver Spring, Maryland 20906 Alan R. Segal, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **SEP 25** 

	1	For State Registrar	Otato	i wai yiai a		tificate of	lealth and I Death		Reg. No.	20	19	324	89
		Decedent's Name (First, Middle)	a, Last)					2. Date of De Month	Day		Year	3. Time of D	
Physicia		Rene Luna Lo	pez					Septem			2009	11:49	P
/Medica Examine		4a. Facility Name (If not institution Gilchrist Hosp	n, give street and nu pice Care	imber)		I	r Location of Death Baltimore			County	of Death	- (Chaha as	Foreign
Funeral Director		5. Social Security Number 219–23–2659	6. Sex 1 ★ 2 □ F	7. Age (In yrs. las	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D Nov. 1	ay, Year)	951	Count	ace (State or ry) alvado	
ъ		Usual Residence of Decedent		10c City	Town or Lo	cation					10	d. Inside City	Limits
larylan s show	ō	10a. State 10b. County Virginia Arl	.ington	Toc. City,	TOWIT OF EO	Arling	ton					1 ☐ Yes	No.
with the N a or 28a-1	Director	10e. Street and Number 3218 S. 9th St	reet			10f. Zip Code	22204				vador		
ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar must be notified at or other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2√3√Mar  3 □ Widowed 4 □ Divorced	12. Was Dec Armed F ried 1 Yes	2 <b>XX</b> Io		Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1 ▼Yes 2 □ No Specify: Other					e - America k, White, e		>
n 72 hour	Completed	15. Deceder (Specify only highe	nt's Education est grade completed		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	rking	16b. K		usiness/Ind	,	
within iene. than	E O	Elementary/Secondary (0-12)	College	(1-4or 5+)		Farmer					rming	3	
2 should be filed within and Mental Hygiene. Is marked other than " aumatic event, the Mes	Be	17. Father's Name (First, Middle, Jose Casti		Cruz Lop	ez		18. Mother's Na	<sub>me (First, Midd.</sub> Carmen I		Surnan	ne) 		
2 should h and Me 7 Is mark traumatio	2	19a. Informant's Name/Relation: Paula Antonia	ship (Type. Print) (	spuouse) e Luna	19b. Maili 3218	ng Address (Stree	t and Number or F	Arlingto	on, V	r Town, irgi	State, Zip nia	Code) 22204	
es 1 and of Health if item 27 or other to		20a. Method of Disposition  Burial 2 □ Cremation		20b. Pl	ace of Disponentery, cre	osition (Name of matory or other pla	ace)	Date 5/2009	20c. L	ocation -	- City or To	wn, State Marylai	 nd
permit. Pages 1 and Department of Heal Important: If Item 2 any Injury or other once.		4 □ Donation 5 □ Other (	Specify)	Mrt.	2	oln Cemet	ess of Facility Jo	ohn M. '	Taylo	r Fi	ınera.	1 Home	
B a T B B	1	23a. Part 1. Enter the disease, of	E, M	Wei_			of Glouce			mag	OIIS	Approximate	
Physician //Medical Examiner bublished and the physician and the p	dical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due t	o (or as a consequence of o (or as a consequence o (or a conseque	uence of):	Oma_	Mul-	tor					
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1   Yes 2   No 9   Unknown   Unknown   23c. If yes, outcome of pregnancy   1   Live birth 2   Fetal death   3   Ectopic pregnancy   5   Other (specify)   9   Unknown						1			ate of delivionth	e of delivery nth Day Year	
ires that th signed by d be detacl	ğ	art II. Other biginnount con-	tions contributing to	death but not rest	ulting in the	underlying cause (	given in Part I.		id tobacco		ntribute to 3∐ Pro	the cause of obably	death? Unkno
<b>sing Physician:</b> The law requir n. After this certificate has been s' funeral director, page 2 should I	Completed							24a. W a p 1 □ Ye	utopsy erformed2		prior to c death?	opsy findings ompletion of	availa
an: T	Be		cal				26. Place of D	eath (Check or	ly one)			701	6
ysich is cer direct	To B		Hospital: 1	☐ Inpatient 2 ☐		ent 3 DOA		Home 5 ☐ F		-	ther (Spec	city) (0 / )(	hri
ng Ph fter th neral	l E	27. Manner of Death 1 ☑ Natural 5 ☐ Pend	/A	ate of Injury fo <i>nth</i> , Day, Year)	28b. Time Injury	of 28c. Ir	njuryat /ork? ∐Yes 2∐No	28d. Descri	be now in	ury occi	urrea		
Attend r death ector: by the	Certification:	2 Accident inversions Accident 5 Cou	stigation	ace of Injury - At h	ome, farm, s			28f. Locatio City or	n (Street Town, Sta	and Nur	n <i>ber</i> or Ru	ral Route Nu	mber,
spitai hours neral y filled			ying Physician: To eal Examiner: On the	ne basis of examina	owledge, de	ath occurred at the investigation, in m	e time, date and pl ny opinion, death o	ace, and due to ccurred at the ti	the cause me, date a	e(s) and and place	manner as e, and due	stated. to the cause	(s)
To the Ho within 24   To the Fu completel	Medical	one) 29b. Signature and title of cert	and r	nanner stated.			ense number				ned (Monti	h, Day, Year)	
)		30. Name and address of pers	on who completed	cause of death (Ite	m 23a) (Typ	e, Print)	16010	- R	14	10	XIII	M/ =	212
	) tate strar	NEP 2.3	2009	2. Registrar's Sign	acles ature	ST DU	Te 410	3, 10	4/1		XE	1111	14

			For State Registrar	State of	of Maryla		artmen			nd Mental H	Hygier Reg. N	2007	32490
F 85	Discourse in		1. Decedent's Name (First, Mid	ldle, Last)						2. Date of Month		ay Year	3. Time of Death
	Physic /Medi		Leon	В		Langf	ord					23,200 <sup>s</sup>	10:05 A.M
	Exami		4a. Facility Name (If not institut	ion, give street and nu	m <i>ber)</i>	-	4b. City,	Town, or	Location of D	Death	4	c. County of Deal	
			118 Carlisle						Spring			Montgo	
P	Funeral	1	5. Social Security Number	6. Sex 1 □ M 2 □ F	7. Age (In yrs	. last birthday Yrs.	) If Under Months		If Under 24 Hours	Min. (Month,			hplace (State or Foreign ountry)
<i>3</i> ().	Director		231-34-0031 Usual Residence of Decedent	1.	84	115.				01/0	9/192	25 Pota	acagi,N.C.
	land ow		10a. State 10b. Coun	ty	10c. C	ity, Town or L	ocation						10d. Inside City Limits
	Mary Feb	ţō	Md. Mar			G-1 1							1√2 Yes 2 No
	r 28a	Director	10e. Street and Number	ntgomery		Silve	10f. Zip				10g. 0	Citizen of What Co	puntry?
	h with	0	118 Carlisle	Drive					2090	14		U.S.A.	
	deat	Funeral	11. Marital Status	12. Was Dec	edent Ever in t	J.S. 13.	Was Deced	dent of Hi		? (Specify Yes or Puerto Rican, etc.)	No-	14. Race - Ame	nican Indian,
9	or its	臣	1 ☐ Never Married 2 ☑ Ma	Armed Fo	ve 2 No 45-	.'46	1 Yes		Specify:	rueno Hican, etc.)		Black, Whit	
	72 hours after death with the Maryland Insture!; or items 23a or 28a-f show dical Examitier must be notified at	d by	3 Widowed 4 Divorce	ed Year or D	ates:	10	10 105	27.3 190	эрвспу.			Specify:	Black
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Maryland	ould be Mental arked o	o Be	Charlie Land							a Cherry		an Sumame,	
2	2 should and Men Is marks	2	19a. Informant's Name/Relation			19b. Mail	ing Address	(Street a				or Town, State, 2	Zin Code)
	27 le	6	Bernice Langfo							Silver Sp			904
Baltimore,	of Heelth of Heelth fitem 27	li i	20a. Method of Disposition	zia, wiic	20b.	Place of Disp cemetery, cre				Date		Location - City or	
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ati	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service			incoln 2	2 Name an	d Addres	s of Facility	0/30/09_		itland,M	
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P) Solid	n to		23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that o	aused the dea	th. Do not en	ter the mod	e of dying	g, such as car	diac or respirator	y arrest,	irigeon,	Approximate Interval Between
4	Physician		Immediate Cause (Final disease or condition	-									Onset and Death
	/Medical		resulting in death)	Due to	tastat:	tc Car(	CIAOMA	-OI	Coton				18 months
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	ed sit	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a consec	quence of):							
	and and al-trar	Examiner	that initiated events resulting in death) Last	c	or as a consec	quence of):							
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28	ficate p phys is the	Physician/Medical		d									
XOD	eath certific ettending pl for use as t	/W	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out	come of pregn	ancy						23d. Date of del	iven
	death s ette d for	icia	in the past 12 months? 1 ☐ Yes 2 ☐ No		inth 2 ☐ Feta ant at time of c		□Ectopic pre □ Other (spe	egnancy ecify)				Month	Day Year
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	law requires that the as been signed by th 2 should be detache	by P	Part II. Dther significant condit	tions contributing to de	eath but not res	sulting in the u	inderlying ca	ause give	n in Part I.	23e. D	id tobacco	use contribute to	the cause of death?
D	w requir been si should I		Type II Di	abetes Mel	litus					1	Yes	2 <b>D</b> No 3□Pr	obably 4 Unknown
ပ္	e law r has be je 2 sh	pje								24a. W	as an stopsy	24b. Were au	topsy findings available completion of cause of
<u>r</u>	The safe	Completed								pe	rformed?	death?	2 No
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10	Physic this caldin	2	1 ☐ Yes 2 🛣 No		npatient 2				4 🗀 14013111	ng Home 5 🗷 R	esidence	6 □Other (Spec	cify)
Division of Vital Records,	ding I	0	27. Manner of Death 1 ☑ Natural 5 ☐ Pend		of Injury h, Day Year)	28b. Time o Injury		Bc. Injury Work		28d. Descrit	e how inj	ury occurred	
2	l or Attending after death. Director: After In by the fune	licat	3 ☐ Suicide 6 ☐ Could		of Injury - At h	ome form of	M		res 2 □ No	204 Legation	- /C44		
2	after after Dire	Certification:	4 Homicide deter	mined 200. Flace	ng, etc. (Special	fy)	reet, factory	, onice		City or	Town, Sta	te)	iral Route Number,
	To the Hospital or Attending Physician: whin 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 A Certify	ing Physician: To the	best of my kno	owledge, deat	h occurred a	at the tim	e date and ol	lace and due to t	he cause/	s) and mannor as	stated
	ne Ho ne Fu letely	edicai	(Check only 2 Medica one)	Examiner: On the ba and mann	isis of examina	ation and/or in	vestigation,	in my op	inion, death o	occurred at the tim	e, date a	nd place, and due	to the cause(s)
	withir To the comp	¥	29b. Signature and title of certifi	er			29c.	License	number		29d. D	ate signed (Monti	n, Day, Year)
			heurs	Wnears	Kall	MD		000	007660		09	/25/09	
1			30. Name and address of person			n 23a) (Type,	Print)						
			Lewis W. Mar			Belcr	est Ro	pad.	Suite	209. Hva	attsv	ille,Md.	20782
	Sta Registr		31. Date filed (Month, Day, Year SFP 2 8 2009		egistrar's Signa	at <del>uro</del>		,		,			-
	ucgisti	a:	2 L L Z O COO3	Leave	13. 14	4000							

		4	For State	State of Maryla		artment of <i>rtificate o</i>			jiene leg. No. 7 A A A	20101			
			Registrar     Decedent's Name (First, Middle, Las.)	)	001	tinoato o	, , , , , , , , , , , , , , , , , , , ,	2. Date of Dea	th	3. Time of Death			
\$P	Physicia		Freeman	Lichty				Month 100	03 2009	11:45PM			
All Sans	/Medic	_	4a. Facility Name (If not institution, give			4b. City, Town	, or Location of Death	10	4c. County of Death				
	Examin	er	1457 Dorsey Ho			Grant	sville		Garrett				
	Funeral		5. Social Security Number 6. Se	x 7. Age (In yr.	s. last birthday)	If Under 1 Ye Months Day	ar If Under 24 Hrs.	8. Date of Birth (Month, Day	9. Birtl	nplace (State or Foreign untry)			
ы	Director		215-42-4668	XM 2□F 90	Yrs.			Jan 30,	1919 Gar	rett			
	pu ,	-	Usual Residence of Decedent  10a, State 10b, County	10c. C	City, Town or Lo	cation		-		10d. Inside City Limits			
	shoved at		Md Garret	t (	aklan	d				1 □Yes 🔀 🔀 No			
	the N	Director	10e. Street and Number			10f. Zip Cod	e		10g. Citizen of What Co	untry?			
	with yard					2155	0		USA				
	ms 2:	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S. 13.		of Hispanic Origin? (S Suban, Mexican, Puert	pecify Yes or No-	14. Race - Ame Black, White				
9	after or ite	Ē	1 Never Married 2 Married	1 Yes 2 No		1 □Yes 2 □xt		o ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (	Specify: Wh				
03	within 72 hours after death with the Manyland ene. Ithan "natural", or items 23a or 28a-f show he Medical Examiner must be notified at	d by	3 Widowed 4 Divorced	Year or Dates:					16b. Kind of Business/				
2-(	72 h "natu dical	Completed	15. Decedent's Ed (Specify only highest grad	ucation de co <i>mpleted)</i>	(Give	dent's Usual Oo kind of work do DO NOT use rei	ne durina most of wor	king	16b. Killa of Business/	industry			
121	within ane. than	dm	Elementary/Secondary (0-12)	College (1-4or 5+)	Far				FArm				
d 2	filed Hygid Ither ant, ti		17. Father's Name (First, Middle, Last)				18. Mother's Nan	ne (First, Middle,	Maiden Surname)				
lan	ld be ental ked c	To Be	Noah S. Lich	ty			Ada	Bender					
ary	shou and M s mar umat		19a. Informant's Name/Relationship (7	ype. Print)		-			er, City or Town, State, 2				
Ž	is 1 and 2 of Health a item 27 is other trai		Noah F. Yoder				y Hotel		intsville,				
ore	of He		20a. Method of Disposition	20b Removal from State	. Place of Dispo cemetery, cre	osition (Name of matory or other	place)	Date	20c. Location - City or	Town, State			
Ĕ	Pag ment ant: i		X Durial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	9	Slabau	gh Cem	e :	37 . 1	Oakland.	MD			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notifiled at once.		21. Signature of Funeral Service Licen	kenly	M	. Ray	dress of Facil別03 Leckemby	North Funera	St Meyers 1 Home	sdale, pa. 15552			
	DE II		23a. Part1. Enter the disease, or com- shock, or heart failure. List only	olications that caused the de one cause on each line.	ath. Do not en	ter the mode of	dying, such as cardia	c or respiratory ar	rest,	Approximate Interval Between Onset and Death			
	Physician		Immediate Cause (Final disease or condition	acesto he	eart to	rilur	7			2 days			
	/Medical		resulting in death)  Due to (or as a consequence of):										
ь	Examiner		Sequentially list conditions,	b. Chronic Systolic heart failure  Due to (or as a consequence of):  c. kheunatic actic & mitral valvadisease year									
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	La Cara de de la colle	L	sti é	mitral	1hlik	Disease	was			
	xecul and al-trar	xan	that initiated events resulting in death) Last	c. Due to (or as a cons	equence of):	ric q	1100 1100	va va					
8760,	cate be executed physician and the burial-transit	dical E	(	atrial fi	brilla	tion	)			geas			
89	ificate g phy: as the	edic								U			
Вох	that the death certific ed by the attending p detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf prec		⊒Ectopic pregna	ancv		23d. Date of de Month	livery Day Year			
	deat e atte	sicie	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at time o		Other (specif)		-	Month	Day			
P.0	at the l by th	Ph.	9 ☐ Unknown  Part II. Other significant conditions of		oculting in the	Inderlying cause	a diven in Part I	23e Did t	obacco use contribute t	the cause of death?			
Ś	ign be	þ	And II. Other significant conditions of	MID:	100 str	7605	given in raiti.	1 🗆 1		robably 4 Unknown			
Orc	w requi been s should	sted	projectioner	- musy	re spre			24a. Was	24h Were 3	utopsy findings available			
3ec	e las has je 2	Completed						auto	psy prior to ormed? death?	completion of cause of			
al	ate pag		OF Management to modical				26 Place of Do	1 Yes ath (Check only o	No 1 □Yes	2 □ No			
or Vital Record		Be c	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2	☐ ER/Outpatie	nt 3□ DOA	Other: 4 Nursing I	- 1	dence 6 □Other (Spe	ecify)			
o		To To	27. Manner of Death	28a. Date of Injury	28b. Time		Injury at Work?		how injury occurred				
ion	Attending F r death. ector: After by the funer	ation	Natural 5 Pending investigation	(Month, Day Year	) Injury		1 ☐ Yes 2 ☐ No						
Division	27. Manner of Death  27. Manner of Death  28. Date of Injury  M 1 20. Infle of Injury  M 1 20. Describe flow injury occurred  Work?  1 20. Describe flow injury occurred  Work?  28. Place of injury - At home, farm, street, factory, office  building, etc. (Specify)  286. Location (Street and Number or Rural Route City or Town, State)								lural Route Number,				
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical Ce	(Check only 2 Medical Exam	ysician: To the best of my niner: On the basis of exam	knowledge, dea	th occurred at the	ne time, date and place my opinion, death occ	e, and due to the curred at the time,	cause(s) and manner a , date and place, and du	s stated. e to the cause(s)			
	thin 2.	Medi	one) 29b. Signature and title of certifier	and manner stated.		29c. Lie	cense number		29d. Date signed (Mor	th, Day, Year)			
	T. W. T. S		Mahaand	a Harry	m	I.	26/50		10-3-2	009			
			30. Name and address of person who	completed cause of death (I	tem 23a) (Type	, Print)		0	10	-/			
			Marcant A Ka	sed Med	888 L	emeric	I Dive	Wa	kland,	009 NJ 21550			
	Sta	ate	31. Date filed (Month, Day, Year)	32. Registrar's Si		Les les							

			1- State Amend Item 8 per fh, g906,08/04/201	nent of Health and M Cate of Death	ental Hyوا ا	giene Reg. No. 💈 📗 🕕	9 32192
	Physici		1. Decedent's Name (First, Middle, Last)  Mary Adelaide McWilliam:		2. Date of Dea Month Sept.	Day Year	3. Time of Death 9 10:00A
4	/Medic Examin			City, Town, or Location of Death	ocpt.	4c. County of Dea	
and a			28088 Almshouse Road  5. Social Security Number   6. Sex   7. Age (In yrs. last birthday)   f1	Oxford Under 1 Year   If Under 24 Hrs.	8. Date of Birt	Talbo	trthplace (State or Foreign
	Funeral Director			nths Days Hours Min.	(Month, Da 12/20/1	y, Year) C	v Jersey
	pu *		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locatio				10d. Inside City Limits
	Aaryla f shov	ŗ		1			1 ☐ Yes 2 🍎 No
	r 28a-	Director	Maryland Talbot Oxford  10e. Street and Number	)f. Zip Code		10g. Citizen of What C	ountry?
	23a o		28088	21654	J		tes of America
36	be filed within 72 hours after death with the Maryland ttal Hygiene. ed other than "natural", or items 23a or 28a-f show event, It a Medical Examinar must be notified at	by Funeral	Armed Forces? If Yes  1 □ Never Married 2 □ Married 1 □ Yes 2 □ No	Decedent of Hispanic Origin? (Sp., specify Cuban, Mexican, Puerto es 2 1/2] No Specify:	ecify Yes or No- Rican, etc.)	Black, Whi	
5-0036	2 hour	ted	15. Decedent's Education 16a. Decedent's	Usual Occupation		16b. Kind of Business	
21218	C 4 30	Completed	(Specify only highest grade completed) (Give kind life. DO N	of work done during most of work OT use retired)	ing		
2	filed within Hygiene. other than "	Co	12 7 Te	eacher/Counse		Educat: Maiden Surname)	ion
an	should be filed withir and Mental Hygiene. s marked other than umatic event, II a M	To Be	Daniel Wentworth Wright	Murie			avis
Maryland	2 shou and N is mar	_	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Ad	dress (Street and Number or Run			, ,
	12 m			088 Almshouse	RC.,	20c. Location - City o	
altimore,			1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State	y or other place)	30/09	Dover, D	
Ħ	permit, Page Department of Important; If any injury or once.			Crematory 9/3			
m —	any Ber		Kancopull love 12	South Second	Street	t, Denton	, MD 21629
			23a. Part1. Einer the disease, or complications that caused the death. Do not enter the shock, or heart failure. List only one cause on each line.	$\cap$	or respiratory ar	rest,	Approximate Interval Between Onset and Death
made of the	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	lancer			21/2418
	Examiner		Due to (or as a consequence of):				
	pe ti	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying  Due to (or as a consequence of):				
	xecute and Il-trans	xam	Cause (Disease or injury that set of the control of				
760	ficate be executed physician and s the burial-transit	edical E	d				
89	rtificat ng phy as th		IF FEMALE:				-
Box	death certific e attending p d for use as f	Physician/M	23b. Was decedent pregnant in the past 12 moni/s? 1 □ Live birth 2 □ Fetal death 3 □ Ecto	ppic pregnancy		23d. Date of de Month	elivery Day Year
o.	the de	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 4 ☐ Pregnant at time of death 5 ☐ Oth 9 ☐ Unknown	er (specify)			
ds, P.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part I.		obacco use contribute res 2 ☑ No 3 ☐ F	to the cause of death?  Probably 4 Unknown
ecords,	law req	Completed			24a. Was a		utopsy findings available
Y	The ate h	July 1			autop perfor 1 □ Yes	med? death?	completion of cause of s 2 □ No
VIta	iclan: Th certificate ector, pag	Be (	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only o	ne)	
0	rding Physician: th. After this certifice funeral director, p	٦.	27. Manner of Death 28a, Date of Injury 28b. Time of	J DOA 4 LI Nursing Ho		lence 6 Other (Sp	ecify)
0	ath. r: Afte	atior	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) Injury 2 ☐ Accident investigation	Work?		,.,	
DIVISION	To the Hospital or Attending Physician: whith 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, it	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fabuilding, etc. (Specify)	ictory, office	28f. Location (S City or Tow	Street and Number or F vn, State)	Rural Route Number,
	ne Hospil n 24 hour ne Funer pletely fill	edical	29a. Certifier (Check only one)  1 □ Certifying Physician: To the best of my knowledge, death occ 2 □ Medical Examiner: On the basis of examination and/or investigand manner stated.	urred at the time, date and place, pation, in my opinion, death occur	and due to the red at the time,	cause(s) and manner date and place, and du	as stated. le to the cause(s)
	With Com	Ž	29b. Signature and title of certifier	29c. License number		29d. Date signed (Mor	oth, Day, Year)
			* IX MUN 74	D39887		4.30	04
-			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	al Drive #30	1 800	ston m	2/601
	Sta		31. Date filed (Month, Day, Year) 32. Pegistrar's Signature	4.1		<u></u>	
	Registra	ar	11CT 1 1 9009 December 1. 1800	The same of the sa			

	State of Maryland / Department of Health and Mental Hygiene  1 - For State Registrar  Certificate of Death  Reg. No. 100 100 100 100 100 100 100 100 100 10								
			Decedent's Name (First, Middle, Last)		- Incate of Be		Reg. N	<u>• 2009</u>	3. Time of Death
	Physic /Medi			ka Constanti	ine John Mavronic	10100		ay Year 23, 2009	10:20 a M
	Exami		4a. Facility Name (If not institution, give street and n	umber)	4b. City, Town, or Loc			c. County of Death	
			Holy Cross Hospital		Silver Sp	ring		Montgor	nery
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birth	Months Dave I	Under 24 Hrs.	B. Date of Birth (Month, Day, Year	9. Birth	place (State or Foreign
	Director		185-16-5249 18 M 2□F	90 \	rs. Months Days H		April 3.	1919 Per	nnsylvania
	pu ,	1	Usual Residence of Decedent				***		
	arylan show	_	10a. State 10b. County	10c. City, Town	or Location			1	0d. Inside City Limits
	Ba-f	Sch	Maryland Montgomery	S	ilver Spring				1 ☐ Yes 2 🛣 No
	or 23	ie	10e. Street and Number		10f. Zip Code		10g. C	itizen of What Cour	ntry?
	th wi	<u></u>	1730 Dublin Drive		20902		US	A	
	ems ems	Funeral Director	11. Marital Status 12. Was De	cedent Ever in U.S.	13. Was Decedent of Hispa If Yes, specify Cuban, M	nic Origin? (Speci	ify Yes or No-	14. Race - Americ	
9	or it	王		2 🗆 No			can, etc.)	Black, White,	etc.
903	ours iral",	db		Dates: WWII	1⊡Yes 2 <b>∳</b> ∑No <i>Si</i>	pecify:		Specify: Wh i	te
21215-0036	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show the Mudical Examinar roust be routified at	Completed	15. Decedent's Education (Specify only highest grade completed	16a.	Decedent's Usual Occupation (Give kind of work done during	n na most of working	16b. I	Kind of Business/In	dustry
2	within ene. than "	du		(1-4or 5+)	life. DO NOT use retired)	g most of working			
6.4	ed w ygiei t, t	ပ္ပြဲ	5+	Ser	nior Economist	t	Dep	t. of Agr	ciculture
n	be filed within 72 hours after death with the Maryla ttal Hyglene. of other than "natural", or items 23a or 28a-f shor event, the Mudgal Examinar roust be rediffed at	Be	17. Father's Name (First, Middle, Last)		18.	Mother's Name (i	First, Middle, Maide	n Surname)	
Maryland	should be f ind Mental   marked oi matic eve	ျ	Theologos Mavronicola	3		Smaragda	Vasilaro	s	
ar		15	19a. Informant's Name/Relationship (Type. Print)	19b.	Mailing Address (Street and I	Number or Rural I	Route Number, City	or Town, State, Zip	Code)
2	and ealth n 27 ier tr		Theo Nicholas/Son		730 Dublin Dri	ive, Silv	ver Sprin	g, MD 209	02
Baltimore,	permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trau		20a. Method of Disposition		Disposition (Name of crematory or other place)	Dat		ocation - City or To	wn, State
Ĕ	Pag nent int: h		1 □ XBurial 2 □ Cremation 3 □ Removal from 4 □ Donation 5 □ Other (Specify)		of Heaven Ceme	'	ot. 28 2009   Si:		
alti	mit. partn ports ports / inju	1	21. Signature of Egneral Service License	, ,		_ ,		iver Spri	ng,Maryland
m	Depa Depa Impo any ii		Muan Cleil	Mary	22. Name and Address of Francis J. ( 500 Universi	Collins H itv Blvd.	Tuneral Ho	ome Inc.	a MD 20901
			23a. Part . Enter the disease, or complications that	caused the death. Do no				VOL SPITI	Approximate
	Physician	0.7	shock, or heart failure. List only one cause on Immediate Cause (Final	each line.	, , , , , , , , , , , , , , , , , , , ,		copilatory arroot,	1	Interval Between Onset and Death
	/Medical		disease or condition resulting in death) Resp.	ratory Fail					
	Examiner			(or as a consequence of	):				
		교	Sequentially list conditions,	nonia (or as a consequence of	١٠.				
	nsit	Examiner	Cause, Enter Underlying		,.			Ī	
	execu n and al-tra	xaı		(or as a consequence of	1:				
8760,	cate be executed physician and the burial-transit	a E		ry Tract In					
		dical	d						
×	attending	Physician/Me	IF FEMALE:	tcome of pregnancy					
Вох	atten for u	ian	in the past 12 months?	birth 2 Fetal death	3 ☐ Ectopic pregnancy			23d. Date of delive Month	ery Day Year
P.O.	the di	ysic	1 ☐ Yes 2 ☐ No 4 ☐ Preg 9 ☐ Unknown 9 ☐ Unk	nant at time of death nown	5 Other (specify)	<del></del>		World	Day real
σ.	rinstoan: The taw requires that the bearn certificate has been signed by the attending ral director, page 2 should be detached for use as	된	Part II. Other significant conditions contributing to co	eath but not requiting in t	he underlying a second of	D. II	00- Biddi		
Division of Vital Records,	signe signe	ð	Dementia, Malnutrition,			rart I.		use contribute to th	
0	w requir	ted			a, Anemia,		1 ∐ Yes 2	∐ No 3∐ Prob	ably 4 ☑ Unknown
ec .	hast hast	Completed	Multiple Decubitus Ulce	rs			24a. Was an autopsy	24b. Were auto	psy findings available
<u> </u>	cate h	్ర					performed?	death?	2 No
ita i	ysician: III	Be (	25. Was case referred to medical examiner?		26.	Place of Death (C		, I Les	2 🗆 110
<u> </u>	this co	.0		Inpatient 2 ER/Outp	Othory		5 🗌 Residence	6 ∏Other (Specifi	()
0 2	After the	Ë	27. Manner of Death 28a. Date		ne of 28c. Injury at		. Describe how inju		/
0	ath.	ă	1 Natural 5 Pending (Mor 2 Accident investigation	an, Day, roan	M 1 ☐Yes	2 🗆 No			
SIN	er de recto	<u>i</u>	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place build	of Injury - At home, farming, etc. (Specify)	, street, factory, office	28f.	Location (Street ar	nd Number or Rura	Route Number,
<u> </u>	ed in ed in	Certification: T	Dulid	ing, etc. ( <i>Opecity)</i>			City or Town, State	9)	
2	hour hour ly fill y		29a. Certifier 1 Certifying Physician: To the	best of my knowledge,	death occurred at the time, da	ate and place, and	d due to the cause(s	s) and manner as st	tated.
2	within 24 hours after death.  To the Funeral Director: After the completely filled in by the funeral	edical	2 Medical Examiner: On the b	asis of examination and/ ner stated.	or investigation, in my opinior	n, death occurred	at the time, date an	d place, and due to	the cause(s)
5	vithi com	ž	29b. Signature and title of certifier		29c. License num	nber	29d. Da	te signed (Month, L	Day, Year)
			Ashirt Mio		D680	96		tember 2	
	5+1	-	30. Name and address of person who completed caus	se of death (Item 23a) /Ti		. •			
					Glen Road, Si	lver Spr	ing, MD 2	0910	
	Stat	e	31. Date filed (Month, Day, Year) 32. F				J, 2		
	Registra	-	SEP 25 2009 /2	egistrar's Signature	ares				

			1 - State of Maryland / Departr	ment of Health iicate of Death		, ,	ene . No. (2) (2) (2)	55151
Physician			1. Decedent's Name (First, Middle, Last)  Rosana F. O'Neill			Date of Death Month	La W	3. Time of Death
/Medi Exami			4a. Facility Name (If not institution, give street and number)  Anne Arundel Medical Center	. City, Town, or Locatio	on of Death	eptember	4c. County of Death	12:45 P™ Arundel
	Funeral	Г	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)		ler 24 Hrs. 8. s Min.	Date of Birth (Month, Day, Ye	9. Birth Cou	place (State or Foreign
	Director		Usual Residence of Decedent		Ma	ay 16, 1		nington
	Maryla a-f shov	ctor	10a. State	Annapo	olis			10d. Inside City Limits 1
	with the	Funeral Director	10e. Street and Number 66 Franklin Street, Unit 102	0f. Zip Code 21401	I	10g.	Citizen of What Court	ntry?
036	should be filed within 72 hours after death with the Maryland at Mental Hyglene. marked other than "natural", or Items 23a or 28a-f show marked event, the Medical Examinations to a coffind at	þ	I Linever Married 2 Married   I Lines 2 Mo	Decedent of Hispanic Cs, specify Cuban, Mexic		y Yes or No- an, etc.)	14. Race - Americ Black, White, Specify: WI	
15-0	in 72 ho n "natur Molical	Completed	(Specify only highest grade completed) (Give kind	s Usual Occupation of work done during mo IOT use retired)	ost of working	165	b. Kind of Business/In	dustry
1212	filed with Hygiene, ther thai		8 Inter	rior Design	ner		nterior Des	sign
_	permit. Pages 1 and 2 should be file Department of Health and Mental H Important: If Item 27 is marked oth any injuy or other traumatic eveni once.	To Be	17. Father's Name (First, Middle, Last)  Guy Lake		ther's Name <i>(Fi</i> Hazel I	irst, Middle, Maid French	den Surname)	
, Mar)			19a. Informant's Name/Relationship (Type. Print)  Carroll O'Neill/husband  19b. Mailing Ad 66 Frank	ddress (Street and Num	nber or Rural Ro	oute Number, Ci	ity or Town, State, Zip napolis, 1	(Code) (ID 21401
nore			20a. Method of Disposition  20b. Place of Disposition  cemetery, crematory  7 collisions to the company of the		Date		Location - City or To	•
Baltimore,	ermit. P epartme nportan ny injur. nce.		4 □ Donation 5 □ Other (Specify) Arlington Na  21. Signature of Funeral Solvice Licensee 22. Nar	me and Address of Faci	_			_
	= e o		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the	Duke of Gl	ouceste	er St.,	Annapolis	MD 21401 Approximate
w. F	hysician		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)	ance		op.natory arroot,		Interval Between Onset and Death
	/Medical		Due to (or as a consequence 4):	-				
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Chisa Underlying Cause (Disease or injury			<del>-</del>		
8/60,	uncate be executed g physician and as the burial-transit		that initiated events resulting in death) Last C Due to (or as a consequence of):					
		Medical	d					
.O. BOX	within 24 bours after death.  To the Funeral Director: After this certificate has been signed by the attending prophetely filled in by the funeral director, page 2 should be detached for use as	Physician/M	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy in the past 12 months? 1 □ Live birth 2 □ Fetal death 3 □ Ecto	opic pregnancy er (specify)			23d. Date of delive Month	ery Day Year
cords, r	en signed t	ğ	Part II. Other significant conditions contributing to death but not resulting in the underly	ing cause given in Part	t I.	23e. Did tobacc	o use contribute to the	e cause of death? ably 4 ☐ Unknown
	ate has be	Completed				24a. Was an autopsy performed	prior to coi death?	osy findings available npletion of cause of
VIIA	certifica rector, p	Be	25. Was case referred to medical examiner?  1	0.41	ce of Death (Ch	1 ☐ Yes 2 ☐ neck only one)	No 1 □Yes	2 LI No
5 6	fter this	on: To	27. Manny of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury	DOA Other: 4 N 28c. Injury at Work?		5 Residence	6 ☐ Other (Specify	()
	after death.  Director: A I in by the fu	Certification:	2 Accident investigation M 3 Suicide 6 Could not be 288 Place of Injury At home form street for	1 ☐ Yes 2 ☐		ocation (Street	and Number or Rura	I Payrin Myrmhau
ביים	eral Dire		building, etc. (Specify)			City or Town, St	ate)	
the Hoe	within 24 hours are to the Funeral I	Medical	29a. Certifier  (Check only one)  1 ☐ Certifying Physician: To the best of my knowledge, death occur  2 ☐ Medical Examiner: On the basis of examination and/or investigation and manyer stated.	irred at the time, date a ation, in my opinion, de	and place, and eath occurred a	due to the cause t the time, date a	e(s) and manner as s and place, and due to	ated. the cause(s)
Ė	To To	2	29b. Signature and title of certifier	29c. License number	45	29d. I	Date signed (Month, I	Day, Year)
•	16		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Right	A	A	manel	ma
	Stat Registra	`	31. Date filed (Month, Day, Year) SEP 23 2009 Server B. Sauce	,			The IN	1'''

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland / Department of State of Maryland / Department of Certificate of Cert			ene g. No. U U 9	32490
ı	Physici	ian	1. Decedent's Name (First, Middle, Last)  NANCY LEE ORMSBY		Date of Death     Month	Day Year	
we have	/Medi Examir			n, or Location of Death	OCTOBE	R 3 2009 4c. County of Dea	
nd!			210 5 17 5 5	ertown		Queen A	
	Funeral Director		5. Social Security Number 161-48-4040 6. Sex 1		8. Date of Birth (Month, Day, 1) Aug 13	9. Bi 20 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	irthplace (State or Foreign Country) elaware
	/land		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	e Mary la-f sh	ctor	MD Queen Anne's Chestertown				1 □Yes 2 No
	vith the	Dire	10e. Street and Number 10f. Zip Code			g. Citizen of What C	ountry?
	ns 23	eral	310 Double Creek Rd. 21620			. S . A .	ovices Indias
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinating the natified at once.	Completed by Funeral Director	Armed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes, Specify C  1 Yes 2 No If Yes, Give Year or Dates:	of Hispanic Origin? (Sp cuban, Mexican, Puerto No <i>Specify:</i>	Rican, etc.)	Black, Whit	
15-(	"natu	letec	15. Decedent's Education 16a. Decedent's Usual Occ (Specify only highest grade completed) (Give kind of work dor	cupation ne during most of work ired)	ing 16	6b. Kind of Business	:/Industry
212	withir jiene. r than	omp	Elementary/Secondary (0-12) College (1-4or 5+) Homemaker			Own Hon	ne
nd	should be filed vand Mental Hygi and Mental Hygi is marked other aumatic event, II	BeC	17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, Ma	iden Surname)	
yla	should be and Mental smarked o	P	John L. Embert, Sr.	Grace			
ā ⊠	and 2 sh ealth and n 27 is n her traun		19a. Informant's Name/Relationship (Type. Print)  19b. Mailing Address (Street and Street and Stree				
Jre,	ss 1 ar of Hea item ;		20a. Method of Disposition 20b. Place of Disposition (Name of			c. Location - City or	
Ē	Pages Iment of Itant: If ite		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	em. 10/	7/09   8	St. Geor	ges, DE.
Baltimore, Maryland	permit. Page Department of Important: If any injury or once.		21. Signature Funer Service La Sencee M00510 22. Name and Add Galena F	ress of Facility Cuneral H Cross S	ome of S	Stephen	L Schaech 21635
E	Physician /Medical		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of d shock, or heart failure. List only one cause on each line.	lying, such as cardiac	or respiratory arres	t,	Approximate Interval Between
-			Immediate Cause (Final disease or condition resulting in dealin)				Onset and Death
	Examiner		Due to (or as a consequence of):				1 40
-	pa ti	iner	Sequentially list conditions, and any in autility of the first cause. Enter Underlying Cause (Disease or injury that initiated events considerated to the considerate consider		-		1 014
	and and II-trans	Examiner	Cause (Disease or injury that initiated events c				
68760,	rtificate be executed ng physician and as the burial-transit	Cal E	d d				
89	rtificat ng phy as the	Medical	IF SEAM F.				
0	the death cer by the attendin ached for use	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnant at time of death 5 □ Other (specify) 9 □ Unknown	ncy		23d. Date of de Month	elivery Day Year
<u>a</u> .	e law requires that the d has been signed by the le 2 should be detached	by Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause of		23e. Did tobac	co use contribute to	o the cause of death?
ğ	requires that been signed b	ted t	Sepsis, activitis, pulmonary embe	nrif	1 □ Yes	2 No 3 □ P	robably 4 🗌 Unknown
Hec	: The law r cate has be page 2 sh	Completed	- GEND		24a. Was an autopsy performer	d? prior to death?	utopsy findings available completion of cause of
Vital	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?  Hospital:	26. Place of Death	(Check only one)		
	g Physer this eral di	일	27. Manner of Death 28a. Cate of Injury 28b. Time of 28c. Injury 28c. Injury 28b. Time of 28c. Injury	jury at	me 5 Residence 28d. Describe how	e 6 ☐ Other (Spe	rcify)
	Attending It death. ector: After by the funer	atio	1 Natural 5 Pending (Month, Day, Year) Injury W 2 Accident investigation M 1	ork? □Yes 2□No		ingary obsarrou	
UNISION	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification: T	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)		28f. Location (Stree City or Town, S	et and Number or Ru State)	ural Route Number,
	spital nours a neral I	ဦ	29a. Certifier  Charten and Certifying Physician: To the best of my knowledge, death occurred at the	time date and place	and due to the caus	en(s) and manner a	c stated
R	he Ho in 24 h he Fur	Medical	(Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my and manner stated.	opinion, death occurr	ed at the time, date	and place, and due	to the cause(s)
	Nith Com	Σ		nse number	29d.	. Date signed (Mont	h, Day, Year)
		-		051735		10/5/09	j
	40		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Frederick Delboy, Map D. 6602 Church H	ı ba ili	Chastart	Own MD	21620
	Stat Registra		31. Date filed (Month, Day, Year) OCT 09 2009 32. Registrars Signaturi 8. Jane	πα. (	CHESCET (	-OWII, MD	. 21020

				Indelible Ink. Ensure All Copies	
				Pepartment of Health and Mental Hyg Certificate of Death	giene <sub>Reg. No.</sub> 2019 521,96
~	Physic /Medi		1. Decedent's Name (First, Middle, Last)  TOWARD SYDNEY PINI	DER, JR. 2. Date of Dea Month SEPT	29 2009 1631 M
100	Exami	ner	4a. Facility Name (If not institution, give street and number)  MEMORIAL HDSPITAL	4b. Ofty, Town, or Location of Death	4c. County of Death
	Funeral Director		216-54-999/	hday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day Rous) Nov. 17	9. Birthplace (State or Foreign Country)
	aryland show	]	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town	or Location	10d. Inside City Limits
	ith the Mar or 28a-f st	Funeral Director	Maryland Talbot Quee	en Anne	1 □ Yes 2 ၨ️No l0g. Citizen of What Country?
	eath with is 23a or	eral	30059 Queen Anne Highway  11. Marital Status  12. Was Decedent Ever in U.S.		nited States of Ame
980	hours after death with the Maryland tural", or items 23a or 28a-f show al Expriner rust be netfled at		11. Marital Status  1 □ Never Married 2 ☑ Married  3 □ Widowed 4 □ Divorced  12. Was Decedent Ever in U.S.  Armed Forces?  1 □ Yes 2 ☑ No.  If Yes, Give  Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)     □ Yes 2 ☑No Specify:	14. Race - American Indian, Black, White, etc.  Specify: Caucasian
21215-0036	n 72 n "na"	Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired)	16b. Kind of Business/Industry
	iled wit Hygien Iher th nt, the		12 HS Grad  17. Father's Name (First, Middle, Last)	Self Employed	Carpenter
Maryland	ges 1 and 2 should be filed within it of Health and Mental Hygiene. If item 27 is marked other than "for other traumatic event, the Mark	To Be	Howard Sydney Pinder, Sr.	18. Mother's Name (First, Middle, I Elizabeth	<u>'</u>
Aary	2 shou and N is mai		19a. Informant's Name/Relationship (Type. Print) 19b.	Mailing Address (Street and Number or Rural Route Number	r, City or Town, State, Zip Code) 21657
	s 1 and F Health tem 27 other t			0059 Queen Anne Highway Disposition (Name of certain of the place)	, Queen Anne, MD  20c. Location - City or Town, State
Baltimore,	Pages ment of I ant; If ite		TESTINAL 2 COMMISSION STATE		Hillsboro, Maryland
Balt	permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is rr any injury or other traum once.		21. gnature of Funeral Service Licenses Mour	22. Name and Address of Facility Moore Fundal South Second St., D	eral Home, P.A.
	Physician /Medical Examiner		23a. Part1. Enter the disease or complications that caused the death. Do no shock, or heart failure. List only one cruse on each line.  Immediate Cause (Final disease or condition resulting in death)  a.  ue to (or as a consequence of	ot enter the mode of dying, such as cardiac or respiratory arm  CARDIAC TN FAXCTIO  35TIC CARDIO Y ASCULAR	Interval Between Onset and Death
760,	te be executed ysician and e burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  b. Due to (or as a consequence of c.	):	Disease Shronic
P.O. Box 687	The law requires that the death certificate to ate has been signed by the attending physicage 2 should be detached for use as the base.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Year
	w requires tha s been signed should be det	þ	Part II. Other significant conditions contributing to death but not resulting in t	_	oacco use contribute to the cause of death? es 2 ☐ No 3 ☐ Probably 4 🗗 Unknown
Vital Records,	ian: The law re rtificate has ber ctor, page 2 sho	Completed		24a. Was ar autops perforn 1 □ Yes 2	v prior to completion of cause of
f Vit	ysic is ce direc	To Be	25. Was case referred to medical examiner?  1	26. Place of Death (Check only one patient 3 DOA Other: 4 Nursing Home 5 Reside	
	ling After fune	Certification: 1	27. Manner of Death  1 Natural 5 Pending investigation 3 Suicide 6 Could not be  28a. Date of Injury (Month, Day, Year)  28b. Tir (Month, Day, Year)  28b. Tir (Month, Day, Year)	me of ury At Work?  M 28c. Injury at Work?  1  Yes 2 No	w injury occurred  reet and Number or Rural Route Number,
Ö	ital or urs afte ral Dir lled in	Cert	Formulae Building, etc. (Specify)	City or Town	n, State)
	To the Hospital or Attenc within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Creek only one)  2 Medical Examiner: On the basis of examination and/and manner stated.	death occurred at the time, date and place, and due to the co for investigation, in my opinion, death occurred at the time, date	ause(s) and manner as stated. ate and place, and due to the cause(s)
D	77. iv v 00.	_	200 Signature and title of carrier Septil Septil  Outstand Company of additional accordance of a carrier who completed course of doubt (Ham 23a) (To	D14664	9d. Date signed (Month, Day, Year)  SENT 30 2009
			Christian E. JENSEN MD, PORH	690 DENTON MD 216	29
	Sta Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signature	1	
DHI	MH 17 Rev 1/20		OCT 0 1 2009 Amer A.	par	
				ORIGINAL	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year September Month **Physician** Leon J. Robinson 0705 M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Seasons Hospice Randallstown Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Min. | 5/02/52 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** 1 X M 2 □ F 216-60-5605 57 MD Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygene. Important: if Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, if a least contined any injury or other traumatic event, if a least Examine train is a rottined. 1 ∏Yes 2 XNo Director MD Howard Columbia 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10307 Twin River Rd. 21044 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Tes 2 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 X No altimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Black Specify þ 3 ☐ Widowed 4X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hotel Registrant Hotel 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dumis Robinson Margaret E. Colbert ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marguerite A. Jackson/Sister <u>10307 Twin Rivers Rd., Columbia, MD 21044</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Crest Lawn Mem. Gdns. 9/30/2009 |Marriottsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH, Inc. 21. Signature / Fineral Servicy Licensee M01411 4112 Old Columbia Pike, Ellicott City, MD 21043 23a. Part1(Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** a. Non Small Coll disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions Due to or as a consequence of Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last law requires that the death certificate be executed burial-tran and Due to (or as a consequence of): Box 68760, physician Physician/Medical the attending p for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy certificate ☐Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Special 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral ( 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After t Hospital or Attending 1 🔣 Natural 5 Pending n 24 hours after death.

e Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the I within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

Open

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5401 Old Court Rd., Randallstown, MD 21133 Deborah Burton

31. Date filed (Month

32. Fegistrar's Signature

bor 27 2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Harry Jeffrey Raffensperger 4:55P M Sept 20 2009 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Arundel Anne Crofton Convelesant Center Crofton 8. Date of Birth (Month, Day, Year) 11-29-1939 9. Birthplace (State or Foreign Country) Maryland Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Funeral Days 1x M 2 Months Hours Director 69 220-36-3840 show 10d. Inside City Limits 10b. Count 10c. City. Town or Location ral", or items 23a or 28a-f shor Examiner must be notified at 10a. State Director Prince George's Bowie 1 KKyes 2 No Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20715 U.S.A. Funeral 7304 Westwind Court 12. Was Decedent Ever in U.S. Armed Forces?

1 ▼ Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian. Black, White, etc 2 1 Never Married 2 X Married White Baltimore, Maryland 21215-0036 72 hours after 1 ☐ Yes 2 🖾 ¥lo Specify: "natural", 3 Divorced 4 Divorced Completed Year or Dates. 62-68 permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) U.S. Dept of Education Elementary/Seconday (0-12) College (1-4 or 5+) Financial Analyst 4 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Catherine Elizabeth Jeffries Harry Parker Raffensperger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7304 Westwind Court, Bowie, Maryland 20715 19a. Informant's Name/Relationship (Type, Print) Wilda Peters Raffensperger-wife 20c. Location - City or Town, State 20b. Place of Disposition (Name of Sacred Heart Catholic Church Cemetery 1 XX Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 9-26-2009 Bowie, Maryland 22. Name and Address of Facility Robert E. Evans Funeral Home 21, Signature 16000 Annapolis Road, Bowie, Maryland 20715 r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, t only one cause on each line. Approximate Interval Between Onset and Death 23a. Part 1. Enter the di shock, or heart fail Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence signed by the attending physician and abe detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) \_\_\_\_ in the past 12 months? Month Day Year Pregnant at time of death 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🜠 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an s certificate has b lirector, page 2 s autopsy death? perform 1 ☐ Yes 2 ☐ No Yes 2 No ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be Hospital Other: 2 No 1 🔲 Yes ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work?
1 Yes 2 No 1 Natural 5 Pending 2 Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined City or Town, State within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

hane

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

3 😾 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

sowie

29d. Date signed (Month, Day, Year)

Lynn D. Reich

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

09-07527 State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day Y September 26, 2009 2019 hrs Lynn Diane Reich **Medical Examiner** 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Baltimore** 23 South Stricker Street, Apt. 2 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Months Davs Hours Director Country) Maryland 2 X F Yrs 46 not available Sept.30,1962 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Yes 2 No Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code n tified at 23 South Stricker St., Apt2 21223 United States ö 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married Yes White after Divorced If Yes, Give Year 1 Yes 2 X No specify: Specify 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 72.1 mit. Pages 1 and 2 should be filed within 72 partment of Health and Mental Hygiene. portant: If item 27 is marked other than "ury or other traumatic event, the M dical 1 21215-0036 12 Unemployed 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ronald G. Reich Kay Wilmot 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Baltimore, MD Gary Reich / Brother 1113 Primrose Court, Annapolis, MD 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a, Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State permit. Page Department Baltimore Crematory 10/1/09 Baltimore, Maryland Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Funeral Serv icense John M. Taylor Funeral Home, In 147 Duke of Gloucester St.. Annapolis. 23a. Plant I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a COmplications of aortic valve replacement Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical ttending physician are use as the burial -X UNPENDED AMENDED 23a, PII, 27, permE, g897 11/17/09 TT Box 68760 23d Date of delivery 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live hirth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown has been signed by the att 2 should be detached for q Unknown 23e. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Yes 2 ✓ No 3 Probably 4 Unknown Cocaine use Completed Records. 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? r this certificate had director, page 2 ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi completely filled in by the funeral director, 26.Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? Hospital: 1 Other $_4$ Nursing Home 5 Residence 6 Other: Scene DOA Inpatient 2 ER/Outpatient 3 No 1 Yes ٩ 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Injury Certification: 1 X Natural Pending 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide determined Homicide 29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E September 27, 2009 - 1 MW 30. Name and address of person who completed cause of death (Item 23a) 0 Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month . Registrar's Signature

State Registra

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